Legislative Document (1945) No. 78A

STATE OF NEW YORK

PLANNING FOR THE CARE OF THE CHRONICALLY ILL IN NEW YORK STATE—REGIONAL ASPECTS

NEW YORK STATE COMMISSION
TO FORMULATE A LONG RANGE
HEALTH PROGRAM
also known as
NEW YORK (STATE)
HEALTH PREPAREDNESS COMMISSION

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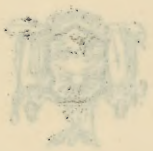

PLANNING FOR THE CARE OF THE CHRONICALLY ILL IN NEW YORK STATE—REGIONAL ASPECTS

STATE OF NEW YORK

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ALBANY, NEW YORK

To His Excellency, the Governor of the State of New York, and to the Honorable Members of the Legislature of the State of New York:

The New York State Commission to Formulate a Long Range Health Program has the honor to submit for favorable consideration the report of its activities and investigations undertaken pursuant to the powers and duties conferred upon it by chapter 682 of the Laws of 1938, chapter 933 of the Laws of 1939, chapter 798 of the Laws of 1940, chapter 483 of the Laws of 1941, chapter 362 of the Laws of 1942, chapter 207 of the Laws of 1943 and chapter 279 of the Laws of 1944.

Respectfully submitted,

LEE B. MAILLER, *Chairman*, Assemblyman
Special Consultant USPHS

WALTER J. MAHONEY, *Vice-Chairman*, Senator

ELSIE M. BOND, *Secretary*

Legislative Members of Commission

Senators	*Members of Assembly*
Robert S. Bainbridge	Thomas A. Dwyer
Richard A. DiCostanzo	Theodore Hill, Jr.
Fred G. Moritt	Richard J. Sherman
	William M. Stuart
	Robert Walmsley

Non-Legislative Members of Commission

George Baehr, M.D.
Albert D. Kaiser, M.D.
R. V. Rickcord

Ex-Officio Members of Commission

Edward S. Godfrey, Jr., M.D.
Commissioner
State Department of Health

Robert T. Lansdale,
Commissioner
State Department of Social Welfare

Commission Staff

Leon A. Fischel, *Counsel and Executive Assistant to Chairman*

Hildegarde Wagner, *Medical Social Consultant*

Isabel McCaffrey, *Consulting Statistician*

Edward S. Rogers, M.D., *Director of Planning for Care of the Chronically Ill*

Morton L. Levin, M.D., *Research Consultant*

Hyman Goldstein, Ph.D., *Statistician*

The Commission acknowledges its appreciation to Miss Pirie Perenyi, Graphic Statistician, in drafting the maps which bear her signature herein.

FOREWORD

The New York State Health Preparedness Commission is currently engaged in formulating a State program for the care of the chronically ill. Chronic illness, often called "the unseen plague," is a problem of increasingly grave proportions. It has been estimated that 177 of every 1,000 persons suffer from some chronic disease, and 11 thereof are disabled. This prevalence is doubled among persons of low income.

The tools to arrest and cure some chronic diseases are now being developed by medical science. However, many of the chronically ill do not receive the full possible benefits of modern medical science and tend to become a permanent drain upon the health, social and economic resources of their families and communities. General hospitals usually can provide only short-term care for these individuals. Physicians and medical and social agencies, both official and voluntary, are continually faced with the constantly pressing and expending problem of how to furnish care for longer periods of time. Although custodial care is being offered by some county home infirmaries, few have found it possible to give medical care of the quality really needed. In fact, even though they may be able to pay for it, many chronically ill find extreme difficulty in securing adequate medical, hospital and nursing care.

From a humanitarian viewpoint, a chronically ill individual should receive the type of care his condition requires. Socially and economically, neither the State nor the local areas can afford to lose the productive capacity of any citizen, particularly if this can be prevented. Not only he, but his dependents become a potential burden on the community. Some means must be developed to provide adequate facilities and services for the care of the chronically ill.

New York City is providing, and plans to extend, special hospital and allied services for chronic cases. A number of counties in upstate New York are planning extension and new construction of their infirmaries.

An overall analysis of the situation indicates that except in the few more populous counties, such facilities can neither be built, equipped, staffed nor operated to provide adequate medical, nursing or custodial care because of the prohibitive per diem cost per patient of a small operating unit. It is the judgment of the Commission that the problem of caring for the chronically ill requires a State-wide program, sufficiently flexible and elastic to allow for variations in the different counties and communities, formulated in (1) the light of existing local and State-wide official, private and voluntary institutions and services, (2) the necessity for coordination to secure a maximum benefit, and (3) the medical and nursing requirements of the patients, whether provided in institutions or in their own homes.

The questions posed by this specific problem are similar to those involved in the distribution of quality medical service generally. Hence, it was apparent that the natural tendency to use health and medical care facilities on a regional basis, geographically speaking, would have to be carefully weighed in any proposed planning. A study was accordingly made as a result of which tentative primary and secondary medical care regions and centers have been projected for New York State. The teaching resources, manpower, technical services and facilities in each area, grouped around a center of medical quality, have been taken into consideration in arriving at the tentative boundaries which are set forth in this report. Using these as a basis, the Commission is engaged in formulating a plan which it hopes will help meet the problem of caring for the chronically ill.

INTRODUCTION

The previous reports of the New York State Commission to Formulate a Long Range Health Program, created by chapter 682 of the Laws of 1938, contain the historical background and data dealing with the Commission's work.

This statute stated in part as follows:

"Section 1. The legislature hereby finds and declares as the policy of the state that the health of the inhabitants of the state is a matter of state concern; that adequate medical care is an essential element of public health; that the present efforts of the medical profession in providing medical care should be supplemented by the state and local governments; that the problem of economic need and the problem of providing adequate medical care are not identical and may require different approaches for their ultimate solution; and that a long range state health program directed toward all groups of the population should be formulated and carried out.

"§ 3. It shall be the duty of the commission hereby created to recommend to the legislature a long range state health program in accordance with the policy declared in section one of this act; to investigate, study and analyze ways and means for improving and maintaining the health of the people of the state including but not limited to the following:

"(a) proposals designed to minimize the risk of illness by increasing preventive efforts through extension of public health services;

"(b) proposals for furnishing adequate medical care for persons of low income, the cost to be met from public funds;

"(c) proposals making available public funds for the support of medical education and for studies, investigations and procedures for raising the standards of medical practice;

"(d) proposals making available public funds for medical research in recognition of the need for maintaining high standards of practice in both preventive and curative medicine;

"(e) proposals making public funds available to hospitals which render services to persons of low income and for laboratory, diagnostic and consultative services;

"(f) the utilization of private institutions in the allocation of public funds for any of the foregoing so long as the services rendered by them are designed to carry out the objectives of such program and the declared policy of the state;

"(g) the investigation and planning of the measures proposed by the commission and the direction and execution of such measures by persons expert in the work involved, and

"(h) proposals designed to effect adequate administration and supervision of the health functions of the state government and if deemed advisable the consolidation under a separate department of all federal and state health and medical services and activities. The study of any subject, matter or thing adjudged by the commission to be relevant or germane to the subjects of inquiry hereunder shall be deemed within the scope of the investigation directed to be made by this act."

In 1938, 1939 and 1940, acting pursuant to its original charge, the Commission engaged in a number of studies relating to health and medical care, collected and analyzed a mass of varied factual and statistical data, held public hearings and conferences and drew up Ten Preliminary Recommendations and Ten Recommendations for Further Study.[1,2,3]

While these functions were being carried on, in the latter part of 1940 at the direction of the executive branch of the State Government, the Commission became active in the field of health defense;[4] chapter 483 of the Laws of 1941 continuing the Commission, stated in part:

". . . the commission hereby continued shall have the power, and it shall be its duty, on its own motion or upon the request of the governor or of the New York state council of defense, to undertake, supervise or direct (a) the making of studies, surveys and analyses of the nature, extent, location and availability for use of the health facilities and resources of the state and (b) the formulation and execution of plans for organization, coordination and mobilization of all services and skills pertaining to health for state and national defense purposes, and for the coordination of all activities affecting health or related thereto."

On June 17, 1941, pursuant to the direction of the Governor's office, the name of the Commission was changed to the "New York State Health Preparedness Commission" and it was thereafter designated the Health and Medical Section of the State Defense Council, afterwards the State War Council. Later

[1] Legislative Document (1939) No. 97, Preliminary Report of New York State Commission to Formulate a Long Range Health Program.

[2] Legislative Document (1940) No. 91, Medical Care in New York State, 1939.

[3] Legislative Document (1941) No. 83, Interim Report of the New York State Commission to Formulate a Long Range Health Program.

[4] Legislative Document (1941) No. 43, Special Report of the New York State Commission to Formulate a Long Range Health Program on Health Mobilization for Defense.

Legislative Document (1941) No. 64, Special Report of the New York State Commission to Formulate a Long Range Health Program on the State-Wide Health Preparedness Conference Sponsored by the New York State Defense Council and the Health Commission.

on, the creation and administration of the Emergency Medical Service of the State Office of Civilian Protection was placed under its jurisdiction with the specific directive to concentrate its efforts in this field. This meant a change in the emphasis of the Commission's program and it found itself functioning as a quasi-administrative agency engaged in the field of health defense and its collateral activities. A detailed account of the creation and the workings of the Emergency Medical Service and its related functions was fully set forth in two previous Commission reports.[5,6]

On May 17, 1945, the State Director of Civilian Protection issued Memorandum No. 97 placing the members of the New York State Civilian Protection Force on a reserve basis. The Chairman of the Commission, as State Chief of the Emergency Medical Service, sent a letter to each local Chief of the Emergency Medical Service thanking them for their services and cooperation. A copy of this letter is set forth in Appendix A, p. 61.

On August 23, 1945, the Acting State Director of Civilian Protection issued Memorandum No. 103 permitting the demobilization of the Civilian Protection Forces.

Shortly thereafter, pursuant to the suggestion of the American Red Cross, a letter was sent to each local Chief of Emergency Medical Service indicating a procedure by means of which the machinery created because of the emergency might be continued. A copy of this communication is set forth in Appendix A, p. 63.

The future of the Emergency Medical Service rests with the initiative of the local communities and the degree to which they are receptive to assuming responsibility for this work. The Commission hopes that some machinery may be developed whereby localities will remain ready to cope with any civilian disaster that might arise.

When the Emergency Medical Service reached the maintenance stage requiring merely supervisory attention, the Commission, mindful of its original charge, continued its studies and planning. Its work on the County Studies is set forth in its 1943–1944 Report.[7]

At this point, since the Commission is in reality carrying on from where it left off in 1940, before its work was directed into the field of preparing for war and carrying on during the war, it might not be amiss to indicate the point of view of the Commission as set forth in some of its previous reports.

In its Interim Report the Commission stated:

"From a long range point of view, the Commission finds itself confronted with problems involving both health and social evolution. It is cognizant of the fact that each and every health service that it has examined is merely part of a vast tapestry, the threads of which are so entwined as to affect and react upon each other. Nutrition and the distribution of surplus foods, recreation, physical education, housing, adequate medical care, public health nursing, school health services, hospitalization, maternal and child welfare services, tuberculosis and venereal disease control services, industrial hygiene and workmen's compensation, health education and environmental sanitation and the control of communicable diseases—to mention a few health fields superficially dissimilar—are all manifestations of man's effort in his war upon disease.

"There is little clarity or symmetry in the vast number of governmental agencies in the health field—be they Federal, State, County, City, Town or Village. The same is true of the multiplicity of voluntary agencies operating in similar areas. It is difficult to catalogue and differentiate them in a manner that does not show immense overlapping and duplication. To plan for the future requires objective analysis and study. It would not be very difficult to construct on paper a long range health plan which would be logical, complete and effective, both clinically and administratively. We find, however, as a practical proposition, the ground occupied, but by no means covered, with a variety of existing health services. These services, each with its own purpose and degree of efficiency, have grown up or been established in a piece-meal, independent and more or less haphazard fashion. As a result, there is overlapping and unnecessary complication and duplication, and yet gaps exist in the provisions needed for a reasonably complete medical care and public health service. Moreover, the question arises as to whether certain existing areas of health administration are suitably and properly placed from a departmental point of view. Any proposal for reform, however, must take into consideration the historical and practical circumstances which have brought them into being.

"Therefore, in formulating a long range health program for the State, the Commission seeks to recognize existing conditions and circumstances so as to adjust, modify and extend present services and administrative arrangements to produce as far as possible effective coordination and unification. Should any new system for distributing medical care be promulgated by law, due consideration must be given existing governmental and voluntary agencies performing health functions."[8]

In its 1941–1942 Report in discussing the effect of the war on the Commission's activity the following was set forth:

"The creation and activation of the Emergency Medical Service was a task of considerable proportion, particularly since practically all of those

[5] Legislative Document (1942) No. 64, 1941–1942 Report of the New York State Commission to Formulate a Long Range Health Program—Health Preparedness Commission.

[6] Legislative Document (1943) No. 75, 1942–1943 Report of the New York State Commission to Formulate a Long Range Health Program—Health Preparedness Commission.

[7] Legislative Document (1944) No. 56A, 1943–1944 Report of the New York State Commission to Formulate a Long Range Health Program—Health Preparedness Commission.

[8] Leg. Doc. (1941) No. 83, *op. cit.*, pp. 14–15.

engaged in it are working on a voluntary basis. After Pearl Harbor, the apathy that had existed in some areas towards the Emergency Medical Service changed over night to an intense desire to accomplish results. Fortunately, the foundation of the Emergency Medical Service had been laid in the creation of the local Health Preparedness Committees. Had they not existed, the work would have been much more difficult and much precious time lost.

"Emergency Medical Service brought with it a host of collateral activities and their resulting problems. The Commission found itself engaged in a task that required considerable public relations activity in addition to actual creative planning of administrative machinery. Availability of physicians, hospital facilities and nursing services, blood and plasma reserves, training of physicians in the treatment of wounds of chemical warfare, health aspects of possible evacuation measures, duties of pharmacists in the event of enemy action, relation of the American Red Cross and other voluntary groups to the Emergency Medical Service, were some of the matters that had to be analyzed, evaluated, and determined so that they might be given their proper place in this program.

"Those familiar with the previous history of the Commission can thus see how these new activities, brought about as a result of emergency conditions, tended to a change in emphasis in the various fields of the Commission's work. However, the Commission is very hopeful that all of these activities, since they are communal in aspect, will aid the various localities by encouraging the direction of their thinking along community lines. Without such thinking at the local level, planning of State and national scope will be of little avail. It is only when people understand what they are doing in their own community that they begin to receive the real benefits of their action.

"It is hoped that the experience gained in such new developments will serve to inform the medical profession, its allied personnel and the public, as to the changes and outlook required to make possible any improvement in the machinery of the distribution of medical care, while retaining the high scientific standards of its present good quality.

"The various studies of the Commission have convinced it that plans to solve health problems may readily be drawn on the State and national level; however, unless such proposals take into consideration the local conditions peculiar to rural as well as urban areas, they will invariably lose their effectiveness. A study of the historical background of health problems generally, will indicate that they are eventually solved by an educational process. Proposed legislation is merely the crystallization that has resulted from scientific and lay thought devoted to these problems. The education involved may be either that of the physician, the health worker, or the public, or all three, but the process must take place. Moreover, this simple principle applies even more to the problems of distribution of medical care than it does to those involving environmental sanitation and communicable disease control.

"The recognition of health as a community problem is the first realization that community action is required to help solve such problem. What the war has done and is continuing to do with greatly increasing emphasis is to make each community health conscious."[9]

The County Studies,[10] basic in character, pointed up certain problems for the Commission's attention. One of the most important of these is that of chronic illness. At the same time there appeared very clear indications of the regional aspects of the distribution of medical care.

The conception of the regional aspects of the distribution of medical care had previousy been a subject of comment by the Commission.

In 1939 the Commission made a number of Preliminary Recommendations, among which was the following:

"9. A reorientation of the role of the approved general hospital, public or private, in the preventive and curative services of the community, so that:

"a. Unnecessary duplication of accommodations or wasteful competition on a local or regional basis may be eliminated;

"b. The general practitioner and his patient may make more effective use of the consultant, specialist and laboratory services and modern therapeutic and diagnostic equipment which should be available in an approved general hospital and outpatient department.

"c. The general practitioner may have an increased opportunity to treat cases that fall within his sphere of competence, in the patient's home, in the physician's office, or in the hospital. Also, that the general practitioner may have a better opportunity to enjoy the professional benefits incident to working on a hospital staff with his colleagues.

"d. Social service in the hospital may be integrated with community social services to provide more effective methods of communication between the hospital and the general practitioner in the interests of continuity of treatment to promote the patient's restoration to health or the best possible social adjustment in the light of his condition."[11]

As a result of the various studies engaged in by the Commission the following Comment was made on this Preliminary Recommendation in the 1940 Report.

> **"Comment** (PR–9).—The central position of the general hospital in any long range health program, State or local, has been recognized in most of the studies made by this Commission. These studies were designed to reveal the current status and relationship of the general hospital in the practice of medicine in New York State and the role which it plays in meeting the health needs of both the individual and the community.

[9] Leg. Doc. (1942) No. 64, *op. cit.*, pp. 16–17.
[10] Leg. Doc. (1944) No. 56A, *op. cit.*
[11] Leg. Doc. (1939) No. 97, *op. cit.*, p. 5.

"The study of medical care in welfare districts was undertaken to reveal the extent to which care in a general hospital was requested and utilized, both by persons receiving other forms of public assistance and by persons otherwise able to provide for themselves but unable to pay for necessary medical care. The study of medical care programs operated by welfare departments was planned to reveal the interrelationships between the agencies in the community having responsibility for the provision of medical care, including hospitalization, for persons unable to provide it for themselves.

"The study of patients discharged from hospital wards in New York State and the study of the payment status of patients receiving care in hospital wards or clinics, was undertaken in the belief that an intimate analysis of the circumstances surrounding the admission and care of individual patients in hospital wards or clinics, including the economic factors, should reveal a graphic picture of the current functions of the general hospital in the distribution of medical care in New York State. These studies were designed also to reveal the various ways by which responsible governmental agencies could use more effectively the hospitals operated by some municipalities and the extensive facilities available in the widely distributed voluntary hospitals in the State.

"A general hospital cannot be used effectively unless a trained staff, including competent physicians, is readily available to make the most effective use of its facilities. Another study by the Commission was devoted to the problems of graduate medical education, including intern training, and was devised to reveal hospital staff practices in the voluntary hospitals in upstate New York. These staff practices were considered in the light of the standards adopted by the American College of Surgeons and the American Medical Association in order to appraise both the quantity and the quality of the medical care provided by these hospitals.

"Other studies made by the Commission endeavored to define the central position of the general hospital in the existing and proposed plans for the provision of medical care on a voluntary prepayment basis, as well as its relationship to the control of communicable disease, and certain other diseases of public health importance which are now considered to be essential activities of a well-rounded public health program."[12]

The following Recommendation for Further Study was also made in the 1939 Report:

"8. Studies of the need for diagnostic laboratory, and consultant and specialist services, as well as a modern clinical, diagnostic and therapeutic armamentarium available to all physicians, through public facility, if necessary. In meeting this need, consideration should be given to the full utilization of existing approved general hospitals."[13]

After the Commission had made inquiry along these lines the following Comment was made on this Recommendation for Further Study in the 1940 Report:

"Comment (RFS–8).—The extent of the need for diagnostic laboratory, and consultant and specialist services, together with the role of general hospitals in meeting such needs is revealed in a number of major studies made by the Commission. Special consideration was given to the problems involved in the extension of laboratory services."[14]

These Recommendations showed a trend of thought which has recently crystallized itself into the approach which considers the distribution of medical care in terms of its regional aspects. Their validity seems to be borne out by the planning taking place today at the State and national level.

In its 1939 Report the Commission touched on the problem of the care of the chronically ill in the following Recommendation for Further Study:

"7. Studies of the need for additional expansion of governmental health and medical care services to meet special health problems such as:

"a. Pneumonia control;

"b. Cancer control;

"c. Syphilis control;

"d. Tuberculosis control—including hospitalization, rehabilitation, and after care;

"e. Dental care and dental hygiene, especially for children;

"f. Drug addiction control, including the provision of a State farm colony for treatment and rehabilitation of addicts;

"g. Physical rehabilitation and social adjustment for permanently handicapped children, as an integral part of the existing State and local program for the care of remediable crippled children; and

"h. Care of chronic illness and infirmity, including adult physical rehabilitation for restoration of earning capacity."[15]

As a result of the Commission's studies the following Comment was made thereon in the 1940 Report:

"Comment (RFS–7).—Each of the special health problems referred to in this recommendation have been subjects of study by the State Department of Health which has responsibility for the administration of these State sponsored programs. Therefore, the Commission to avoid expensive duplication of effort, has not made detailed studies of each individual problem but has considered these problems in their relationships to a number of the broad studies which it has conducted during the current year. While separate progress reports are presented with respect to recent developments in a number of these disease control programs, the factors involved in chronic illness and infirmity have been given special emphasis in the Commission's studies relating to medical care in welfare districts and patients discharged from hospital wards."[16]

Item "d" of Recommendation 7 dealing with tuberculosis control is of special interest in view of later developments. The Commission had reported in 1940[17] concerning the confusion in the interpretation of the pertinent sections of the Public Welfare Law, the County Law, and the Public Health Law, with the result that tuberculosis patients who were not definite indigents in many counties had a difficult time in securing hospitalization. It stated:

"This practice of placing hospitalization of tuberculosis on a welfare rather than a public health basis is reported to have a serious direct and indirect influence on the control of the disease. This influence may be felt in the following ways: first, in postponing the admission of patients early in their disease when treatment not only is less

[12] Leg. Doc. (1940) No. 91, *op. cit.*, pp. 11–12.
[13] Leg. Doc. (1939) No. 97, *op. cit.*, p. 7.
[14] Leg. Doc. (1940) No. 91, *op. cit.*, p. 16–17.
[15] Leg. Doc. (1939) No. 97, *op. cit.*, p. 7.
[16] Leg. Doc. (1940) No. 91, *op. cit.*, p. 16.
[17] *Ibid.*, pp. 423–424.

costly but also when the chance of recovery is much greater; second, it increases the opportunity for the spread of the disease in the home and elsewhere due to postponing or preventing the isolation of infectious cases; and, third, particularly in small communities, the information from patients that their families must surrender life insurance policies, increase their mortgages, sell some of their cattle, or in other ways exhaust families' small resources acts as a definite deterrent to other patients who may require hospitalization.

"These conditions which prevail in the few counties where decision as to financial eligibility of patients is made by public welfare officials are reported to be retarding the progress made in our State tuberculosis hospital areas. Although there is no specific provision in the Public Health Law requiring it, the county boards of supervisors refer case reports of patients hospitalized in the State tuberculosis hospitals to the local welfare department for investigation, decision and collection.

"The hospitalization of cases of tuberculosis should not be considered primarily as making provision for medical care on the same basis as is provided for medical care by welfare officials for most other diseases. The hospitalization of patients suffering from tuberculosis is fundamentally and primarily a public service for the protection of the health of other people. The treatment, however, of the individual, after he is admitted to the hospital, is a personal matter with that patient and does include, of course, such medical and surgical measures as may be necessary to rehabilitate such patient."

The following suggestions were made:

"*The Need for Amendments to Present Laws:* It is apparent that there is an urgent need for amendments to the present laws, as well as changes in present practice, to ensure hospitalization for tuberculosis on a public health rather than a welfare basis. Considering the economic status of all but a very small percentage of tuberculosis patients, it is believed that the amount of revenue which can be justly obtained through the payment for hospital care by patients or relatives, would be greater if the Public Health Law were changed, making it permissible rather than obligatory to pay in whole or in part when the patient can afford to do so.

"As a matter of actual experience, the yield in dollars in tuberculosis hospitals by direct payment of patients or their relatives is such an insignificant amount that, at least in sections of this State, the cost of making the investigations for all patients admitted, which are made in accordance with present laws, exceeds the amount of revenue which has been obtained from the few patients who were determined as able to pay for hospitalization.

"The fact that but a small percentage of families in which tuberculosis is a problem can afford to pay for hospital care is evidenced by national and state surveys, and figures compiled by the Division of Tuberculosis, New York State Department of Health."

Finally in the 1946 session of the Legislature, the "dollar sign" was taken off the treatment of tuberculosis. The bill introduced by Assemblyman Lee B. Mailler stated:

> "Availability of facilities for diagnosis, care and treatment without cost. Notwithstanding any inconsistent provision of this chapter or of any other general, special or local law or city charter, care and treatment provided by a state, county or city for persons suffering from tuberculosis, and diagnoses, tests, studies and analyses for the discovery of tuberculosis, shall be available without cost or charge to any resident of the state who is suffering from tuberculosis or is suspected of having tuberculosis. Any such person who volunteers to assume and pay for the cost of such care and treatment or for the cost of such diagnosis, test, study or analysis shall be permitted to do so; but no state, county, city or other public official shall request or require such payment or make, or cause to be made, any inquiry or investigation for the purpose of determining the ability of such person or of his legally responsible relatives to pay therefor."

This legislation passed both houses and was signed by the Governor on April 24, 1946, becoming chapter 999 of the Laws of 1946.[18]

In its report on Medical Care in New York State, 1939,[19] there was set forth a study of the physical condition of persons admitted to 62 City and County Homes during 1939. There were 13,570 residents in public homes for the year ending December 31, 1938, of which 6,007 were first admissions, indicating a turnover in public home population of 44.3 per cent. The records dealing with the first admissions during the year, 6,007 in number, were reviewed. A reason for admission was given in 5,982 cases. Of these cases 4,923 or 82.3 per cent were admitted because of age, chronic illness, or because they needed medical attention. At least 2,890 or 48.3 per cent of all first admissions were admitted because of chronic disease —and it is probable that in many of the remainder, chronic illness was a contributory factor toward admission.

Although New York City has 55.1 per cent of the total population of the State, it had only 755 or 12.6 per cent of the first admissions. The upstate area with 44.9 per cent of the population had 5,252 or 87.4 per cent of the total number of first admissions. It was indicated that a possible deduction that might be drawn from these figures is that New York City, possessing adequate hospital and clinic facilities, is hesitant in sending cases needing medical attention to public homes. On the other hand, since upstate counties do not have the elaborate medical facilities available in New York City, they are more prone to

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[18] A copy of the bill may be found in Appendix A, p. 65.
[19] Leg. Doc. (1940) No. 91, *op. cit.*, *p.* 183.

send cases requiring medical attention to public homes because of the expense involved in hospital care.

Another interesting point ascertained was that the cardio-vascular disease group was the highest in number among the admissions, consisting of 1,902 diagnoses or 56.8 per cent of the total number of diagnoses submitted.

In the Interim Report of the Commission in 1941, there was set forth the results of a study on "Medical Care and Economic Factors in the Experience of a Group of Discharged Ward Patients" New York State (Exclusive of New York City), 1939.[20]

This study dealt with the medical care experiences of a group of residents of upstate New York. The individuals investigated by the Commission were patients discharged in 1939 from the wards of 11 general hospitals in 10 representative communities of upstate New York. An analysis of medical and economic data obtained from hospital and welfare department records and from interviews conducted by public health nurses with 1,601 discharged ward patients (or their families) was set forth. The material represented the ordinary run of cases (emergency accident and psychiatric cases excepted). The hospitals studied varied widely as to size and organization and were located in communities representing many of the types of population density and health and welfare organization prevalent in New York State.

The general medical and surgical cases were divided into groups according to type of clinical courses as follows: cases with recent sudden onset, recurrent attacks, and long-standing continuous conditions. It was found that a higher proportion of patients with long-standing continuous conditions were cared for in the wards of the hospitals in large urban centers than in those of rural areas. The hospitals in the rural areas were used to a great extent for emergency situations and had high surgical rates, while the hospitals in urban centers were used for the hospitalization of a relatively high proportion of chronic conditions.

The importance of the problems connected with the care of the chronically ill was becoming apparent in these studies.

With the transition to wartime activities, particularly the local Health Preparedness Committees and later the Emergency Medical Service, it was necessary to lay aside temporarily the Commission planning in this direction.

However, the County Studies made by the Commission in 1944–1945 served to point up the importance of the problem of the care of the chronically ill. In its 1943–1944 Report,[21] in the Conclusions and Suggestions dealing with the County Studies, the following was stated relative to the chronically ill:

> "There is a trend toward an increase in the older age group in these areas. Chronic illness is usually associated with, but not necessarily confined to the older age group. The care of the chronically ill is a problem of growing importance in all of these counties. Most of the chronically ill either have or will have depleted their financial resources. These conditions corroborate the factual evidence submitted by physicians, hospitals, public health nurses and social workers concerning other states and cities in New York State and elsewhere that chronic illness is increasing and that families of such ill persons are less and less able to assume responsibility for them. Some pertinent local observations in Ontario County are: (1) There are an increasing number of chronically ill patients. (2) Many receive inadequate care in their own homes. (3) Community resources for their care are limited or inadequate. (4) The general hospitals are adverse to admitting the chronically ill, preferring to allocate the beds to acute and emergency cases. (5) The nursing homes in the county differ widely in quality and good nursing home care is not readily available, either because of lack of beds or inadequate financial capacity of patients. (6) Many of the chronically ill either have, or soon will have, depleted their financial resources. (7) The aged chronically ill are frequently treated harshly by younger members of the family, often by their own children. (8) Grandchildren of the aged chronically ill, rebelling against the restrictions imposed upon the home by illness, exemplify delinquent behavior.
>
> "It seems that cities are more aware of these problems than the rural areas, probably because living conditions in the country are less crowded and therefore conducive to a more tolerant attitude toward chronic patients being cared for at home. Adequate care at home depends upon the willingness and competence of relatives, the physical condition of the home and the diagnosis. This burden of care might be alleviated by public health nurses assisting in teaching families proper methods of care and, where necessary, periodically assisting in lifting patients, changing beds and giving baths. At present this service is not generally provided as part of the local official public health nursing programs. Other chronically ill patients are cared for in nursing homes or general hospitals, either at personal or public expense.
>
> "In view of the financial condition of the patients, it seems that the problem calls for public solution on the basis of intelligent, comprehensive overall planning. It is not solely a problem of custodial care. Although the chronically ill do require institutional medical care for prolonged periods, usually in excess of two or three months and some of them are incurable, a number can be rehabilitated. Any chronic hospital service for these patients should be closely integrated with a general hospital service and every effort made to salvage those cases that can be returned to a productive, self-sustaining status."

The regional aspect of the distribution of medical services was emphasized in the following excerpt of the 1943–1944 Report.

[20] Leg. Doc. (1941) No. 83, *op. cit.*, pp. 89–140.
[21] Leg. Doc. (1944) No. 56A, *op. cit.*, pp. 16–17.

"Medical care in New York State, both as respects services and facilities, seems to be more often on a regional than on a county or local base, particularly with the advent of modern transportation.

"In Washington County, it was noted that actually the medical and hospital service is regional, the residents making substantial use of specialists, therapists and hospitals in Glens Falls, Ticonderoga, Troy, Albany and Rutland, Vermont. Some of the residents of neighboring counties and Vermont use Washington County facilities. Although there are a number of qualified specialists and consultants in Ontario County, some special therapy and surgical service are availed of in nearby Rochester. Conversely, local hospital facilities are used by residents of other counties and Pennsylvania. Seneca County is not self-sufficient, even in peacetime, in general hospital beds, approved laboratory service, consultant service, special therapy and special surgery. Although providing some of these services, it is partially dependent on neighboring Auburn, Geneva, Ithaca, Rochester and Syracuse. Under prewar conditions, although Niagara County was relatively self-sufficient in health and medical care facilities, it depended on Buffalo and Rochester for highly specialized diagnostic, surgical and therapy services."[22]

It can thus be seen that patients went to places where they thought they could receive the best treatment for what ailed them. This included not only medical personnel but hospital and nursing facilities. The quality of medical care has always been of paramount importance to the Commission, and ways and means of improving it have been the subject of continued investigation. The natural tendency to use health and medical care facilities on a regional basis because of a demand for quality medical service seems to the Commission to be of such vital importance that it must be carefully considered in any long-range planning. The teaching resources, personnel, technical services and facilities in each area, grouped around a center of medical quality, if properly developed and coordinated, can be of invaluable assistance in making medical care of good quality available to all who wish to use it.

[22] *Ibid.*, pp. 15–16.

THE PROBLEM OF THE CARE OF THE CHRONICALLY ILL

In its work at the community and county level in carrying on the County Studies,[23] the local difficulties in meeting the problem of the care of the chronically ill were being constantly brought to the Commission's attention. In view of the vast proportions and ramifications of this problem, it was deemed that the Commission should have a clear understanding of the various aspects involved before undertaking any definite action in this direction. It was accordingly decided to call a small representative informal conference of technically qualified individuals whose previous background and experience in the field of the chronically ill eminently fitted them to be consulted concerning possible plans to help meet this problem.

The Conference to Discuss the Need for and Means of Formulating a State Program for the Care of the Chronically Ill was held at the Commission office in New York City on September 21, 1944.

Invitations had been sent to the proposed conferees three weeks prior to this date. They were accompanied by a brief summary of the problem of the chronically ill as seen by the Commission, a tentative agenda for the meeting, and a request for any additional suggestions for inclusion on the agenda.

Doctor George Baehr presided. The following invitees were present:

Dr. George Baehr
Dr. Ernst P. Boas
Miss Elsie M. Bond
Dr. Louis I. Dublin
Miss Mary Gibbons (representing Commissioner Lansdale)
Dr. Edward S. Godfrey
Miss Mary C. Jarrett
Dr. Frederick MacCurdy
Dr. George M. MacKenzie
Dr. Basil MacLean
Dr. O. W. H. Mitchell
Dr. Herman G. Weiskotten

The Hon. Lee B. Mailler, Commission Chairman, and two members of the Commission Staff, Leon A. Fischel, Esq., and Miss Hildegarde Wagner, also attended.

A very thorough discussion of the various aspects of the problem ensued. As a result thereof the Conference issued the following statement:

"STATEMENT OF CONFERENCE TO DISCUSS THE NEED FOR AND MEANS OF FORMULATING A STATE PROGRAM FOR THE CARE OF THE CHRONICALLY ILL

"The care of the chronically ill, exclusive of mental disease and tuberculosis, is a problem of grave proportions and gives every indication of becoming even more important because of the progressive aging of our population. New York City, recognizing the need for adequate medical care in this field, has provided hospital and custodial care facilities for the chronically ill, and is currently planning an extension of its program. However,

[23] *Ibid.*

this remains an unresolved problem in most counties and cities of upstate New York. Therefore the more immediate consideration should be directed to its solution in these localities.

"Representatives of the State Department of Health, the State Department of Mental Hygiene, the State Department of Social Welfare, local public welfare officials, many practicing physicians, superintendents of general hospitals and recent studies emphasize the urgent need for more prompt and adequate medical care for chronically ill persons. Their number is increasing annually as the proportion of the State population in the upper age group rises. The general hospitals do not, as a rule, have sufficient beds to admit many chronic cases. Most county home infirmaries are neither built, equipped nor staffed to care properly for such patients. Yet the need is so pressing that a number of counties and cities are planning post-war construction of institutions to care for these individuals, generally without including in their plans provisions for adequate medical service.

"For planning purposes, a chronic illness may be described as one of 2–3 months duration and having an indefinite prognosis. Half the current deaths are due to cardio-vascular-renal conditions, which are chronic illnesses. The National Health Survey and other studies indicate that there are approximately 177 chronically ill persons per 1,000 population, 11 of whom are disabled. This rate is doubled in the "under $2,000" income group. The chronically ill are of all ages but are most prevalent in the population over 45 years old. Incidence also varies with occupation and residence, urban and rural. These data are sufficiently applicable to New York State to warrant their acceptance, as a guide in formulating a State program for care of the chronically ill, particularly since the need for ameliorative steps is so apparent.

"The care of chronically ill patients, both ambulatory and bedridden, varies with individual medical need. The patients fall into three categories: (1) those requiring medical care for diagnosis and treatment; (2) those requiring chiefly skilled nursing care; (3) and those requiring only custodial or attendant care. Such care may be provided at home, in nursing homes or in institutions. It should be recognized that the place of care of the individual patient will vary, dependent upon his changing medical needs, and that continuous medical supervision is necessary regardless of the place, or consecutive places, wherein care is provided.

"Care at home should include medical supervision, visiting bedside nurse and full or part-time housekeeper service, as required, and adequate relief grants in cases of indigency. Nursing homes should be under State or State-local licensure and supervision. Institutional care of two types, active medical and custodial, should be provided. The active medical service can best be provided in a hospital for chronic diseases closely allied with a general hospital and a medical teaching institution of high quality. This hospital for chronic diseases should have a division for custodial care, although most of the custodial care might be provided in each county, or for a group of counties, by improved county home infirmaries under State supervision and with State reimbursement.

"Care for chronically ill patients might best be developed on a regional basis in upstate New York. The number of counties comprising each region would depend upon the distribution of population, the availability of transportation, medical facilities and personnel of each area. The center of care for each region would be a hospital for chronic diseases closely related to a general hospital equipped with adequate diagnostic and therapeutic resources both as regards personnel and facilities, a teaching institution of high quality, the envisioned local custodial institutions, the home bedside nursing program, the practicing physicians and the out-patient services within the region. If properly developed, this coordination would insure early diagnosis, a high quality of continuous medical care and utilize the maximum contribution that each institution and professional group could make to the welfare of the patient. This service cannot usually be provided in less populous localities because of the prohibitive per diem cost of a small operating unit and the limited number of highly qualified professional personnel. These factors would compensate for any disadvantage accruing to patients living at a distance from the hospital.

"All patients medically eligible for hospital and custodial care because of chronic illness should be accepted. Those financially able to pay for part or all of their care should do so. To insure the quality of administration and care, flexibility, coordination and modification as indicated by advances in medical science and varying demands, the program should be supervised by an operating State agency.

"Any adequate program for care of the chronically ill should incorporate and correlate the following:

"1. Encouragement of medical research and medical education regarding the nature, causes and methods of retardation of chronic illness.

"2. Establishment of institutions for the diagnosis and treatment of chronic illness, either incorporating adequate facilities and personnel for medical research and medical teaching programs or closely related to institutions where such programs exist.

"3. Establishment of services to make possible the home care of chronically ill patients whose condition does not demand institutionalization.

"4. Availability of expert guidance to practicing physicians. This is requisite to early recognition of chronic disease and a factor closely linked to its retardation.

"5. Encouragement of medical service in smaller communities and rural areas.

"6. Establishment of services for the economic and social rehabilitation of chronic patients able to profit from such a program.

"Because of the urgent need for adequate care of the chronically ill, and the imminent possibility of structural expansion of some county homes and the likelihood of the establishment of some local programs for the care of the chronically ill, the following suggestions are made for the consideration of the Health Preparedness Commission:

"1. The Health Preparedness Commission, in cooperation with the newly appointed Commission on Medical Care, should appoint a small committee of experts to make practical suggestions for formulating a State plan for the care of the chronically ill.

"2. The Health Preparedness Commission should take steps to inform the proper State and local officials that consideration of the provision of State-aid for the physical extension of county and local institutions for the care of the chronically ill and infirm should be deferred, and that county and local units of government planning to expand such facilities totally with their own financial resources should be urged to consider their programs in the light of recommendations and proposals to be made by the New York State Health Preparedness Commission.

GEORGE BAEHR, M.D.
ERNST P. BOAS, M.D.
ELSIE M. BOND
LOUIS I. DUBLIN
EDWARD S. GODFREY, JR., M.D.
MARY C. JARRETT
ROBERT T. LANSDALE
FREDERICK MACCURDY, M.D.
BASIL MACLEAN, M.D.
O. W. H. MITCHELL, M.D.
HERMAN G. WEISKOTTEN, M.D."

On December 8, 1944, the Commission met and among other business carefully considered the Statement of the Conference. The steps taken relative thereto are set forth in the following extract from the minutes of the meeting:

"The New York State Health Preparedness Commission thanks the individuals who have prepared and approved the foregoing statement and records itself as concurring with the statement, amended as follows:

"1. Item No. 5 on page 2 should read: 'Integration of nursing homes for the custodial care of the chronic sick with the general program for the care of the chronically ill,' and present items No. 5 and No. 6 should become items No. 6 and No. 7.

"2. The first suggestion on page 3 should read: 'The New York State Health Preparedness Commission should appoint a qualified physician, assisted by a small committee of experts to formulate a State plan for the care of the chronically ill.'

"3. The second suggestion on page 3 should read: 'The New York State Health Preparedness Commission should notify the proper State and local officials concerned with providing and extending facilities for the care of the chronically ill of the intention of the Commission to formulate a State plan for the care of the chronically ill.'"

Acting pursuant to the Commission's direction, Assemblyman Mailler appointed a Director of Planning and a small Advisory Committee to assist him.

It is interesting to note that in this connection the Planning Committee for Medical Policies of the Medical Society of the State of New York in its Additional Annual Report to the 1945 House of Delegates stated the following:

"The Problem of the Care of the Chronically Ill.—This brings us now to consideration of the problem of the care of the chronically ill. This matter has been made the subject of a special investigation by the Health Preparedness Commission of the State Legislature, more popularly known as the Mailler Committee. It was your chairman's privilege to sit in as an observer at the meeting on June 15, 1945 of the general advisory committee to this commission. Dr. O. W. H. Mitchell, Chairman of the Public Health and Education Committee, is a member of this advisory group, and because of his illness on that day he asked me to substitute for him.

"It is a matter of general knowledge that the population is progressively aging and that many more people beyond 45 are living today, and also that in the future it is highly probable that this age group will increase. This will project an urgent need for more prompt and adequate medical care for the chronically ill patient. The National Health Survey of several years ago stated that there are approximately 177 chronically ill per 1,000 population, and that this number is doubled in the income groups under $2,000 a year. For the purposes of developing a program for the care of this sector of the population, the Mailler Committee classified these chronically ill into three general groups as follows:

"1. Those requiring medical care for diagnosis and treatment

"2. Those requiring skilled nursing care

"3. Those requiring only custodial or attendant's care

"In keeping with the recommendations of Surgeon General Parran and the Interim Report of the Pepper Committee on Wartime Health and Education, they strongly favor the regional hospitalization idea as the basis for any such care. They feel that nursing homes and institutions for the care of chronic disease can best be provided in a hospital closely allied with a general hospital or a medical

teaching center, and perhaps in improved county home infirmaries, under some form of State supervision. They believe that such a proposal offers the personnel and facilities of a teaching institution and local institutions for custodial care, and that home bedside nursing, the role of the practising physicians, and the outpatient services within the region should be integrated into the plan. They cite the need for a logical master plan for the regionalization of medical services, and feel that all other activities being planned at present should ultimately be fitted into such a plan. Undoubtedly, there will be need for additional hospitals, nursing homes, and convalescent facilities, as well as improvement in the quality of existing facilities.

"Conferences with both hospital administrators and welfare directors reveal that such a plan is generally acceptable. The most troublesome cases are the borderline institutional, mental, and senile cases and those needing long-term nursing care.

"The Commonwealth Fund has proposed a grant to the city of Rochester to conduct an experiment and provide a demonstration of the correlation of urban and rural hospitals. The State blood bank and blood derivatives program, authorized by the Legislature at its session, and now in the process of development, is another factor to be considered in any general plan.

"The American Medical Association has gone on record as favoring the main provisions of S. 191, the Hill-Burton Bill, and has suggested a number of practical amendments. We on the Planning Committee concur in their opinion. Governor Dewey has only recently named the State agency, the Joint Hospital Board, composed of Dr. Edward S. Godfrey, Jr., Health Commissioner of the State of New York, Dr. Frederick MacCurdy, Commissioner of New York State Department of Mental Hygiene, and Mr. Robert T. Lansdale, Social Welfare Commissioner of the State. Assemblyman Lee B. Mailler has been named as Special Advisor to this Board. This Board is to be the official State agency for negotiations with the Federal authorities in the practical application of the purposes of the Hill-Burton Bill in the event Federal monies should be granted to the State for hospital construction or other diagnostic facilities.

"Considerable space and detail has been given to this survey of the background of the Committee's deliberations. It would seem to us that any policy which the State Society may see fit to adopt must give consideration to what Government has in view, and certainly we will have to work more in conjunction with Government in the future in order to get the maximum benefits for the people without destroying any of the free practice of medicine."

The Committee recommended cooperation and collaboration with the present State agencies concerned with the planning for the care of the chronically ill and support of the principles contained in the regional hospitalization idea. These recommendations were later adopted by the State Medical Society.

HEALTH SERVICE REGIONS GENERALLY

The Commission had been advised by the members of its informal conference that care for chronically ill persons might best be developed on a regional basis in upstate New York and that the number of counties comprising each region would depend upon the distribution of population, the availability of transportation, medical facilities and personnel of each area.

In beginning its preliminary work to determine the natural regional pattern of medical, hospital and allied care as well as the public health and social welfare services as it affects the chronically ill in New York State, it was recognized that the needs of this group had a very great deal in common with all members of the population requiring medical care. Since they constitute a large segment of the total of such persons, it is readily apparent that the medical attention, hospital and nursing care and public health services which the chronically ill receive must be furnished by the same physicians, nurses, institutions and agencies that are concerned with rendering service to other groups.

Local, county, regional and State relationships in the distribution of all health services must be carefully considered in relation to any proposed plan for the chronically ill. Any projected plan must be so drawn as to provide for the possibility of its later integration into a larger pattern in the event other developments take place in the health field. For example, the experiments now being carried on in Rochester and its surrounding territory may well indicate steps that should be taken to further the provision and distribution of good quality medical care generally.

The initial work of the Commission in this direction has been directed toward ascertaining the logical geographical boundaries of proposed health service regions and districts in New York State. The outlines submitted are tentative and made for the purposes of broad planning. Further discussion and actual operation may indicate the desirability and necessity of change.

In arriving at these tentative boundaries a variety of characteristics of the State and its population were carefully considered. These included the following: distribution of population, geography, transportation facilities, current administrative areas of departments and agencies, location of physicians in relation to the medical schools from which they graduated, natural flow of population seeking hospital care as measured

by experience with public assistance patients, the flow of patients requiring hospitalization for the treatment of cancer, population flow with respect to trading centers, and the present location of medical centers.

The maps setting forth these proposed geographical boundaries were preliminarily released in June, 1945. Indicating the trends that future planning might take, they met with widespread interest in the various State departments, were useful to communities envisaging the development of hospital services and have been considered and provisionally applied as the basis for the hospital survey and plan of the Joint Hospital Board of the New York State Postwar Public Works Planning Commission.

Fundamentally speaking, there is nothing new in the concept of regionalism of hospital services. In Great Britain, Scotland, France and Australia the desirability of regional planning in this field has long been recognized.

In the United States this thinking was crystallized by the introduction in the United States Senate in 1945 of Senate Bill 191, a bill to authorize grants to the states for surveying their hospitals and public health centers and for planning construction of additional facilities, and to authorize grants to assist in such construction. Extensive hearings had been held previously by a United States Senate Subcommittee on Wartime Health and Education pursuant to "A Resolution Authorizing The Investigation Of The Educational And Physical Fitness Of The Civilian Population As Related To National Defense." One of the products of the work of this Subcommittee was the drafting and introduction of S. 191.

In the Senate Hearings on the bill, one of its sponsors stated that as a result of conferences held with the American Hospital Association, the Protestant Hospital Association, the Catholic Hospital Association, the American Public Health Association and other interested groups, there was unanimous thinking that certain broad general principles be made a part of any Federal-aid legislation. In brief these principles are as follows:

> "First, that any hospital or other health facilities constructed with Federal aid be planned as part of a long-range health development and not as incidental to a public-works program; second, that no Federal funds should go into any health facilities until the need has been demonstrated by a careful survey; third, that construction should be controlled through an agency of the State and not by direct Federal-local negotiation; fourth, that voluntary non-profit hospitals as well as State, county and municipal hospitals shall be eligible for assistance; fifth, that the principle of State's rights and local initiative be preserved and encouraged as essential to the success of any health program."

After lengthy hearings before the Senate Committee on Education and Labor, at which representatives of practically every major professional and other groups interested in health services appeared, the bill was redrafted bearing in mind the various suggestions made and criticisms offered. The bill passed the Senate and is now before the House of Representatives where extensive hearings have been held thereon. It is hoped that eventually this proposed legislation will be enacted.

Indicative of the thinking of voluntary agencies in this field was the action taken by the American Hospital Association in 1944. It appointed a Commission on Hospital Care, which, aided by the United States Public Health Service and three private foundations, is undertaking the task of a national hospital survey having as one of its purposes the development of sound local planning with respect to hospitals.

In January, 1945, the Subcommittee on Local Health Units of the Committee on Administrative Practice of the American Public Health Association, submitted a report, based on extensive study which recommends a fundamental reorganization of local health units throughout the Nation. The recommendations, in general, lend themselves to the integration of preventive services and hospital and other medical services operating on a regional plan.

In January, 1945, Mountin, Pennell and Hoge, of the United States Public Health Service, published an extensive statement on the development of "Health Service Areas." In the foreword they stated specifically that it was neither an expression of policy of the organization with which they are connected nor a forecast of what is to come and that if the funds and the will to proceed on any plan for extending hospital service in a comprehensive way should eventuate, many adjustments would be in order.

In our own State, the Governor has appointed a Joint Hospital Board to serve under the direction of the State Postwar Public Works Planning Commission. Among the responsibilities of this Board are the conduct of a State-wide hospital survey and the development of a program for meeting hospital and health facility needs in the State.

In view of the Commission's work in formulating a plan to care for the chronically ill, it is studying and evaluating the regional aspects of health and medical care services particularly as they relate to this portion of the population.

THE REGIONAL CONCEPT

The field of regional planning is the subject of a broad literature, some of which, although not referring to it specifically, shows its potentialities and possible direction. A few citations will serve to illustrate this point.

Although the report of Mountin, Pennell and Hoge, previously referred to, expresses only their own views, it indicates the thought of those associated with an official governmental agency concerning this problem. A portion thereof is herewith reprinted.

> "There is ample reason for believing that general hospitals are destined to become increasingly important in the evolution of medical care and

health service programs. Pending the time when materials and labor can be released for construction, it is, therefore, highly important that existing plants be studied from the standpoints of location, bed capacity, and broad utility in order that added facilities may complement those already in being. The net result of future developments should be to bring the workshops necessary in the performance of preventive and curative services within easy reach of everyone regardless of his economic position or geographical location. These units should be placed also with a view toward inducing an equable distribution of physicians, dentists, and other personnel involved in carrying out a comprehensive program of health services.

"In the past, hospitals, for the most part, have been established where there seemed some likelihood that revenue derived from patients would be sufficient to insure their continuation. If the location was well chosen, growth usually followed. On the other hand, where economic conditions proved adverse, the hospital tended to remain static or to discontinue operations. In other words, the aggregate of material wealth rather than of human need, in the main, has determined the location and use of hospitals. Facilities and skills as a rule have pyramided in the wealthier and more urban communities; while large segments of the population, either because of location or insufficient income, receive less hospitalization than they need. Furthermore, hospitals, once established, are apt to operate as isolated institutions without much regard to the existence of similar facilities within the community or in the surrounding area. As a result of this attempt to furnish all types of care in a self-sufficient unit, small hospitals, especially in areas lacking wealth and population, are unlikely to be well qualified for much of the work that the community requires; while in the more populous centers unnecessary duplication of facilities is commonly observed.

"Lack of hospital connection has the effect of depriving many physicians of opportunities for continuing education afforded by professional association in well-conducted clinics and staff meetings; for the same reason, they may be denied the use of equipment other than what they can afford to purchase individually. Rural practitioners, especially, have been isolated from advances in modern medical science and technology. Rather than become victims of this situation, physicians and other medical personnel concentrate in centers of wealth and population, thus increasing the maldistribution of medical service.

"A creditable beginning has been made toward laying the foundation for a public health organization in keeping with the needs of this country and its traditions of social service. These departments are handicapped now by lack of physical facilities suited to their needs and in keeping with the position which they should occupy in public esteem. It may be stated conservatively that less than ten percent of health departments are provided with accommodations even approaching reasonable standards of adequacy. Moreover, physical separation between hospitals and health departments tends to perpetuate the custom under which preventive and curative services, figuratively speaking, operate in different worlds rather than in relation to the same individuals.

"Under a less complex order than that which is evolving in the United States, the traditional detachment of hospitals from social forces might be tolerated, especially if medical sciences also were static. In the presence of social and scientific progress, the demand for full utilization of all available resources in the interest of both individual and community health is destined to become irresistible. This trend has been recognized for some time by forward thinking individuals in the fields of hospital and public health administration and by students of health problems. Both the American Hospital Association and the American Public Health Association have recognized the need for cooperation between hospitals and public health agencies. Interest expressed recently by the Federal Congress and by several State legislatures clearly indicates a growing public demand for more adequate health services. However, certain questions need to be resolved before much of this nascent interest can be translated into action. First among these is the development of a functional plan for the delivery of service.

"A plan for coordination of hospitals and health centers

"Some of the preliminary thinking of the United States Public Health Service regarding an integrated system of facilities for hospital care and health service is exemplified by the diagram in figure 1. This chart depicts in schematic fashion a coordinated plan whereby health services and facilities would be integrated through a system of base, district, and rural hospitals and health centers.

"In the system the base hospital would have the most advanced equipment and specialized staff, associated, wherever practicable, with the teaching, research, and study opportunity of a medical school. This hospital would offer diagnosis and treatment to patients with conditions requiring services not available in most local hospitals. Large, well-equipped district hospitals would be strategically located within the area served by the base hospital and would provide general and specialty services beyond the resources of smaller local hospitals; thus only the more complex cases would have to be referred to the base hospital. Other hospitals, including those in the more built-up rural areas, should be prepared to meet the ordinary demands of a community and select for transfer to district and base hospitals those cases requiring highly specialized care. Finally, there would be health centers equipped for diagnosis and treatment of ambulatory patients, as well as for the more traditional health department services. Probably a

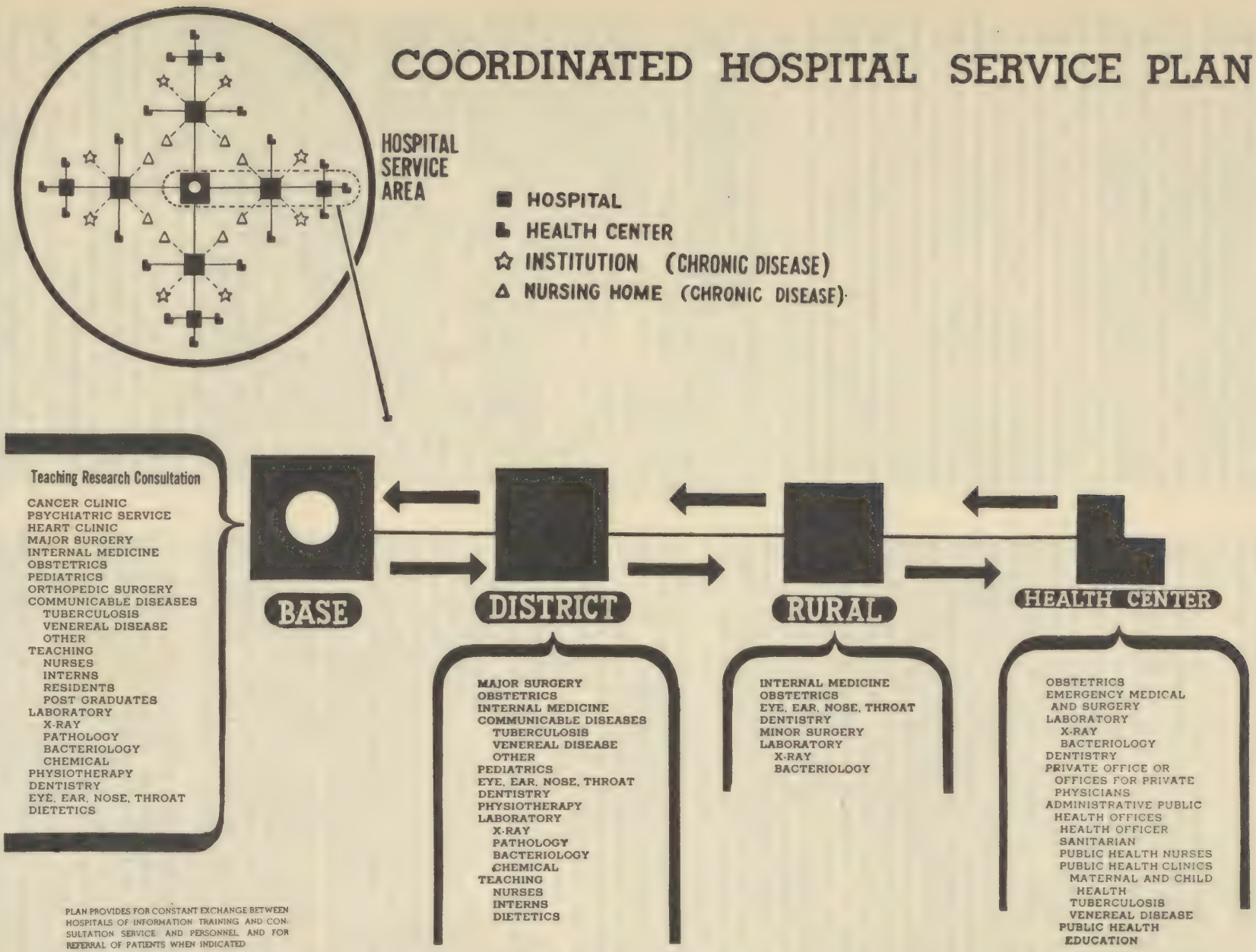


FIGURE 1—A diagram showing relationships among base, district, and rural hospitals and health centers in a coordinated service plan.
Reprinted from Public Health Bulletin No. 292, Federal Security Agency, U. S. Public Health Service.

FIGURE 1

few of these located in sparsely populated areas would contain accommodations for limited hospital service.

"In most communities and in many neighborhoods, there is need for a unit that will localize the activities of the health department and make available to physicians and dentists diagnostic and therapeutic equipment too extensive for them to purchase or operate as individual practitioners. This type of facility is coming to be known as the health center. Preferably, it should be a component part of a hospital, but where this is not feasible, the health center may be erected as a discrete building nearby. In many rural areas, the health center and the outpost type of hospital may be combined both physically and functionally.

"Establishment of hospitals and health centers where they are lacking would supply the physical framework for coordination of health activities within individual communities. In order that professional and technical workers may have opportunities to become acquainted with new procedures and that patients may have access to appropriate diagnostic and therapeutic facilities, an organized system linking small hospitals and health centers with large hospitals and with teaching and research centers is needed. To date this has been accomplished only in small part.

"Local health departments now send a fair proportion of their specimens to State-owned or subsidized laboratories for examination. In a few areas, the more enterprising physicians and local hospitals receive similar services from a large hospital in the same general region. Outside interpretation of X-ray films and electro-cardiograph tracings is even less frequent. Some system should be established whereby any physician and hospital could refer problems in diagnosis or therapy to medical and hospital centers whenever indicated. Such an arrangement for consultation on laboratory specimens, X-ray films, or even case histories often obviates the necessity for actual transportation of patients. Not all such problems would require the assistance of large teaching and research centers. Most, in fact, can be handled by good medium-sized hospitals which are reasonably accessible in distance and time. These secondary or district centers, however, would occasionably find themselves faced with unusual cases on which they would need the help of the best equipped and staffed hospital available. Hence, a system of primary and subsidiary medical centers is suggested.

"Making the educational and consultant resources of large medical centers accessible to all physicians for their continued training after graduation not only would equip them to render service superior in character to that now possible but also would reduce the professional disadvantages of rural areas for physician location. Moreover, arrangements by which interns might receive part of their training in rural hospitals should result in larger proportions of them becoming interested in rural practice. Consultant specialists and university professors attached to the staffs of the primary centers might serve the affiliated centers on a scheduled itinerant basis for demonstration of newly developed medical procedures and on an advisory basis in unusual cases of illness. By developing a group of traveling specialists who periodically would visit smaller cities and utilize local facilities as teaching units, the educational influence of large centers might be extended throughout the region. In addition to the day-by-day training which would be an intimate part of a coordinated scheme, periodic attendance of practicing physicians at intramural refresher courses should be stimulated. What has been said about physicians applies to various categories of personnel—dentists, nurses, dietitians, sanitarians, administrators, and others in health departments and hospitals. Laboratory workers, for example, would benefit from authoritative explanations and demonstrations of new techniques and materials which have come into use since their basic training was completed."[24]

In "Social Security" a statement issued in February 1945 by the "Social Security Committees of American Life Convention, the Life Insurance Association of America, the National Association of Life Underwriters" appears the following excerpt:

"The diagnosis and treatment of serious diseases

"Certain health and welfare services are already widely accepted as functions of local, state, and Federal governments. Sanitation, hospital maintenance, and the control of communicable diseases have long been within the realm of local authorities. The states are maintaining institutions for the care of the tuberculous and the insane. Furthermore, the Social Security Act provides for Federal grants to states to aid in establishing maternal and child welfare services, and recent public health legislation offers additional aid to state and local authorities in combating tuberculosis.

"Such public health programs might well be enlarged and supplemented, particularly in regard to the diagnosis and treatment of serious diseases. A desirable improvement would be a general extension of health centers equipped with a laboratory and other instruments of precision, staffed by specialists familiar with all the modern medical devices, and available for the diagnosis, and in some cases even the treatment, of the more serious disorders. Many hospital and private clinics are already discharging these important functions, making available specialized diagnostic and medical care which the average individual physician is not equipped to render.

"These diagnostic centers, associated in most

[24] The authors also made tentative suggestions relative to proposed regions in New York State, see Appendix A, p. 71.

instances with hospitals, would not replace the general practitioner, who would still be responsible for the great majority of cases. They would, however, make available a more efficient and economical method of using the medical tools and knowledge already developed. This should serve to reduce the cost of adequate medical and hospital care, which has steadily increased with the development of medical science. These diagnostic centers would also have a continuing postgraduate impact upon the general practitioner himself, since their facilities would be of great help in aiding him to maintain high practice standards. Such centers, financed either publicly or privately through gifts, endowments or otherwise, would also greatly facilitate voluntary prepayment plans covering the other costs of medical and hospital care.

"The course of future development

"The organization by which medical care is rendered is going through an evolutionary process tending towards a wider distribution of the more technical and advanced knowledge and facilities. This process will no doubt be greatly hastened after the war, with the building of many new hospitals already being discussed, the expansion of other facilities, and the return of doctors and other medical personnel from military and naval service. Many new advances in medical science will also become more widely available to the civilian population.

"The importance of the role of the doctor in new developments is self-evident. Hence their cooperation is essential in plans for the better distribution of medical care. In addition, the respective fields for voluntary and government action should be carefully worked out, through cautious experimentation utilizing existing machinery as much as possible.

"The problems connected with the development and distribution of medical care are certainly complex and difficult. However, so great are the potential benefits to the health and well-being of the country that it becomes imperative for us to follow a policy of constantly striving to solve them—even though the ideal may change or move on as we approach it."

In the report of the Dean of the School of Medicine of Columbia University, June 30, 1945, Willard C. Rappleye, M.D., makes this statement concerning medical services:

"Modern medical knowledge is now so complex and requires so many different skills that no single individual can master the entire subject. Hence, specialization has developed and must of necessity lead to some form of group responsibility. The nucleus of modern medical care is the hospital center equipped to give full and complete medical, surgical, laboratory, nursing, dietary, and specialized services to patients and to provide at the same time those facilities required by physicians to carry on satisfactory modern medical practice.

"The primary problem of the medical care in this country today is that of providing a reasonable number of hospital and group practice centers which not only will provide for comprehensive professional care in local communities but will serve as the vehicle for a more satisfactory distribution of well-trained young physicians. These younger graduates will not go into practice in local communities with any eagerness unless modern facilities for practice are available. It is in such institutions also that these younger graduates can be more effectively used than they are today. Perhaps the greatest waste of medical manpower and skill in our present system of medical service is that period of five to ten years after completion of hospital training when these young men and women are only partly occupied with the early stages of independent practice.

"The greater development of hospital and group centers where young, energetic, well-trained, and competent individuals could work effectively at a time when they can make their maximum contribution to public welfare would be an important addition to the health services of the country. There should be provided in such hospital centers adequate numbers of technical assistants and other aides who can do, under proper supervision, a great deal of the necessary laboratory and technical services, thus again conserving the time and talents of the highly trained group of young physicians for treating patients, for preventive medicine, and for continued self-development."

Finally, the State Medical Society in October, 1945, adopted as part of the report of its Planning Committee the following recommendation:

"Any discussion of this subject must be prefaced with the assumption that the government has in mind a comprehensive and ambitious program to control the care of the sick. One must distinguish between improvement in the care of the sick—a wider and more complete distribution of the care for the sick—on the one hand, and on the other, the control of the care of the sick.

"Your Planning Committee has given extensive study and review to numerous proposals and projected plans, some actively in operation in local areas of the state, and others representing the combined thinking of medical groups.

"The Planning Committee recommends as an *experiment* that a center for diagnostic aids to physicians practicing in the *rural* districts be set up in a selected location in either or both of the following designated areas:

"(a) The counties of Schuyler, Chenango, and Tioga;

"(b) The north and northeastern part of Delaware County, the southwestern part of Otsego County, and the southeastern part of Schoharie County.

"In so far as possible, these facilities are to be set up by the local communities, and where necessary subsidized by the state if the local community cannot afford to build and operate them. The medically indigent and those unable to pay for the use of these facilities should receive them free. Those who are able to pay should do so to decrease the amount which is necessary for the State or local community to contribute. This would make the centers partially self-sustaining. Details of management, of course, will have to be carefully worked out.

"The Council should be authorized to take such action as may be necessary to carry out these recommendations, including the sponsoring of any necessary legislation. A committee should be designated to cooperate with state or local agencies and with county societies to insure proper functioning and supervision of such diagnostic centers.

"The Committee also recommends that the State Society, through its proper agency, exert its best efforts to secure prompt improvement and expansion of existing facilities for diagnostic aid throughout the state where the need has been shown to exist.

"We are cognizant of the necessity of protecting the public against bureaucratic regimentation of both patients and physicians, and the substitution of an un-American system of medicine for our present high standards of practice."

The previous excerpts come from a wide variety of sources, viz.: (a) physicians working with the United States Public Health Service, (b) the Social Security Committees of organizations in which are represented the largest life insurance companies in the United States, (c) the dean of a leading American medical school and (d) a Planning Committee for Medical Policies of the New York State Medical Society. Despite the difference in their origin and expression, they possess certain similarities that indicate the development of definite trends which should be explored, at least experimentally.

PROPOSED HEALTH SERVICE REGIONS AND DISTRICTS IN NEW YORK STATE

GEOGRAPHICAL BOUNDARIES

The factors weighed in attempting to arrive at tentative regional and district boundaries have previously been set forth in the report. Since they are of extreme importance and to assure a continuity of the material presented, they are being referred to once more in this section. The variety of characteristics of the State and its population which were considered included the following: distribution of population, geography, transportation facilities, current administrative areas of departments and agencies, location of physicians in relation to the medical schools from which they graduated, natural flow of population seeking hospital care as measured by experience with public assistance patients, the flow of patients requiring hospitalization for the treatment of cancer, population flow with respect to trading centers, and the present location of medical centers.

In general, the several factors evaluated follow lines of distribution which are reasonably consistent with and summarized by the marketing map published by Hearst Magazines, Inc., in 1942 (Figure 2). This map is the result of an extensive survey embracing all of the factors mentioned excepting those of a medical nature, and is an accepted standard for commercial planning.

With few exceptions, each city designated on this map as a Principal Trading Center, has in it at least 100 general hospital beds (exclusive of mental disease hospitals, tuberculosis sanatoria and Veterans' Facilities) listed by the American Medical Association and/or approved by the American College of Surgeons. The exceptions are: Malone (82 beds); Saranac Lake (50 beds); Johnstown (0 beds), but which is practically co-existent with Gloversville, which has more than 100 general hospital beds.

Conversely, every city, town or village which has 100 or more general hospital beds appears on the map as a trading center, principal, secondary, or rural, with the exception of Clifton Springs, and Valhalla.

The foregoing facts indicate that, for the most part, hospital facilities tend to concentrate in the same centers as commercial and business facilities. The flow of population toward trading centers probably reflects natural geographical boundaries and transportation facilities and therefore should serve as a reasonable guide for determining natural centers for health services.

THE HEALTH SERVICE REGIONS

There are five principal medical centers in the State, located in Buffalo, Rochester, Syracuse, Albany and New York City. Each of these embraces a group of first class hospitals and an accredited medical school. New York City has five accredited medical schools. Since these centers fulfill all of the basic requirements of a potential regional medical center, and are distributed quite logically across the State, they have been selected as the regional medical centers, and boundaries for five "health service regions" have been described about them, Figure 3, in accordance with the natural population trends as shown in Figure 2. The boundaries, for reasons of administrative expediency, have been drawn along county lines. These five areas are proposed as the five main health service regions.

It is expected that further study and experience may indicate the need for modification of these boundaries. After review by those departments and agencies concerned, appropriate changes should be agreed upon and the plan should stand as the fundamental structure upon which all future planning and development of medical and health services and facilities will be based.

The five health service regions are the main areas in which all facilities and services should be interrelated with the regional center at the hub. The services available in each region, with only rare exceptions, should be comprehensive and self-sufficient. The health service regions which are large and all-inclusive are to be distinguished from the smaller health service districts which they embrace.

Broadly considered, the regional medical centers have two service functions: "inflow" services concerned with the routing of patients or diagnostic specimens *to* a center where larger or special facilities are available; and "outflow" services *from* the centers to smaller districts in connection with clinical and diagnostic aids, teaching and supplying of interns.

The proposed boundaries would, in general, serve to define the limits of outflow services which must be sharply defined for the purpose of administrative organization. They would not necessarily impose any limitations upon the place to which a general practitioner might refer a patient requiring hospitalization or consultation, nor with the place to which a patient might go to seek medical advice. In other words, there is no intention to attempt to interfere with the right of the patient to his choice of physician or hospital.

Since the regions have been developed with the normal travel routes and flow of trade and business relationships in mind, it is quite likely that the majority of patients would normally choose to seek care within their primary region. The ultimate educational effect of the regional association of services and facilities might be expected to further promote this usage.

Persistent interchange of patients between regions outside of the State may be expected, but this does not constitute an obstacle to the smooth operation of the plan. It should be noted also that there are a number of areas in which the normal flow of patients


Marketing Map of NEW YORK
Arranged according to the Principal Trading Centers of the State and their respective Consumer Trading Areas. Each Trading Area is subdivided into the three following markets: (1) The market of First Importance the Principal Trading Center (2) The market of Second Importance the Secondary Trading Centers (3) The market of Third Importance Rural territory in Counties within each area.
LEGEND
Principal Trading Centers
District Center of a Multiple Trading Center Market
Subordinate Urban Cities 25,000 to 100,000 population
Subordinate Urban Cities 10,000 to 25,000 population
Urban Cities 5,000 to 10,000 population
Less than 5,000 population
Trading Area Boundary
County Boundary and Name
State Boundary
Scale of Miles
Index to Cities Within State
See New York Multiple Market Map For Complete Detail
Determined and Arranged by HEARST MAGAZINES INC Marketing Division
Cosmopolitan Good Housekeeping Harper's Bazaar Town & Country House Beautiful American Druggist Motor Motor Boating
Copyright, 1942
CANADA
PENNSYLVANIA
CONNECTICUT
MASSACHUSETTS
VERMONT
N.J.
Drawn by General Drafting Co. Inc., N.Y.

FIGURE 2

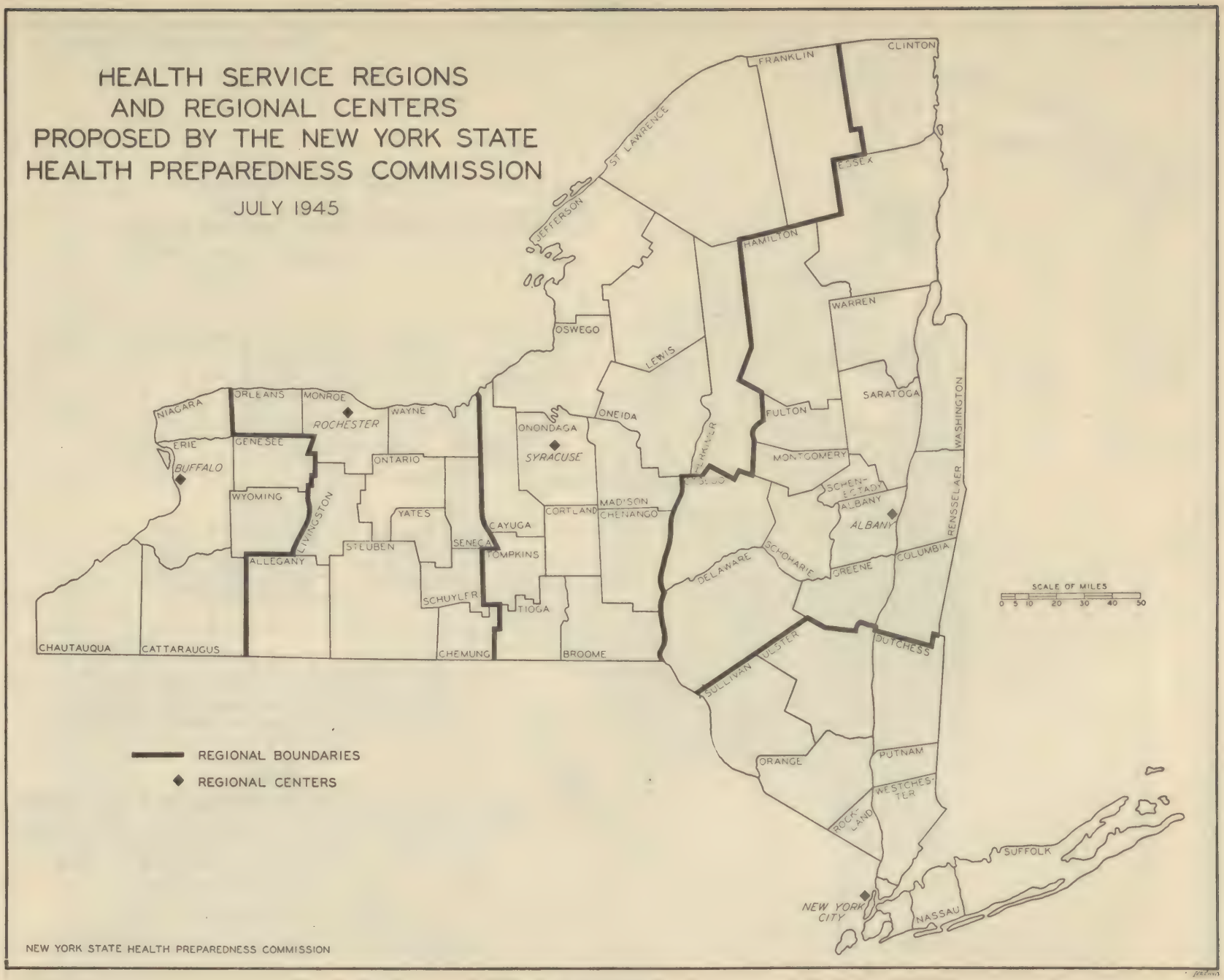

HEALTH SERVICE REGIONS
AND REGIONAL CENTERS
PROPOSED BY THE NEW YORK STATE
HEALTH PREPAREDNESS COMMISSION
JULY 1945
FRANKLIN
CLINTON
ST LAWRENCE
ESSEX
JEFFERSON
HAMILTON
WARREN
OSWEGO
LEWIS
SARATOGA
WASHINGTON
NIAGARA
ORLEANS
MONROE
ROCHESTER
WAYNE
ONONDAGA
ONEIDA
FULTON
ERIE
GENESEE
SYRACUSE
MONTGOMERY
BUFFALO
ONTARIO
SCHEN-ECTADY
ALBANY
WYOMING
MADISON
CORTLAND
CHENANGO
YATES
CAYUGA
ALBANY
RENSSELAER
LIVINGSTON
STEUBEN
SENECA
TOMPKINS
ALLEGANY
SCHOHARIE
GREENE
COLUMBIA
DELAWARE
SCHUYLER
TIOGA
DUTCHESS
ULSTER
SULLIVAN
CHAUTAUQUA
CATTARAUGUS
CHEMUNG
BROOME
ORANGE
PUTNAM
WESTCHES-TER
ROCK-LAND
SUFFOLK
NEW YORK CITY
NASSAU
SCALE OF MILES
0 5 10 20 30 40 50
REGIONAL BOUNDARIES
REGIONAL CENTERS
NEW YORK STATE HEALTH PREPAREDNESS COMMISSION

FIGURE 3

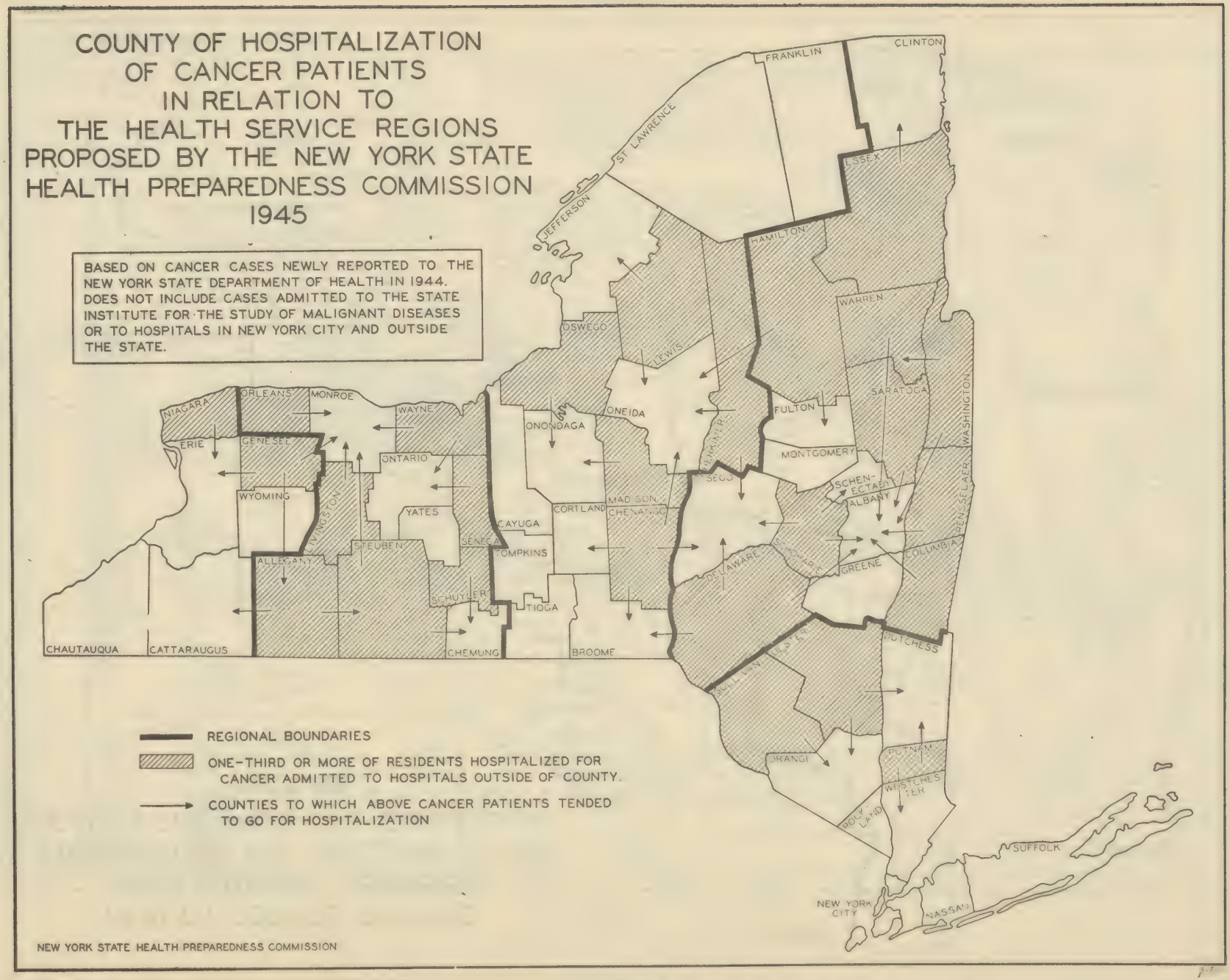

COUNTY OF HOSPITALIZATION
OF CANCER PATIENTS
IN RELATION TO
THE HEALTH SERVICE REGIONS
PROPOSED BY THE NEW YORK STATE
HEALTH PREPAREDNESS COMMISSION
1945
BASED ON CANCER CASES NEWLY REPORTED TO THE NEW YORK STATE DEPARTMENT OF HEALTH IN 1944. DOES NOT INCLUDE CASES ADMITTED TO THE STATE INSTITUTE FOR THE STUDY OF MALIGNANT DISEASES OR TO HOSPITALS IN NEW YORK CITY AND OUTSIDE THE STATE.
FRANKLIN
CLINTON
ST LAWRENCE
ESSEX
JEFFERSON
HAMILTON
WARREN
OSWEGO
LEWIS
ONEIDA
FULTON
SARATOGA
WASHINGTON
ONONDAGA
MONTGOMERY
NIAGARA
ORLEANS
MONROE
WAYNE
ERIE
GENESEE
ONTARIO
SCHENECTADY
ALBANY
WYOMING
LIVINGSTON
YATES
CORTLAND
MADISON
CHENANGO
RENSSELAER
CAYUGA
SENECA
TOMPKINS
STEUBEN
ALLEGANY
DELAWARE
GREENE
COLUMBIA
SCHUYLER
TIOGA
CHAUTAUQUA
CATTARAUGUS
CHEMUNG
BROOME
ULSTER
DUTCHESS
SULLIVAN
ORANGE
PUTNAM
WESTCHESTER
ROCKLAND
SUFFOLK
NEW YORK CITY
NASSAU
REGIONAL BOUNDARIES
ONE-THIRD OR MORE OF RESIDENTS HOSPITALIZED FOR CANCER ADMITTED TO HOSPITALS OUTSIDE OF COUNTY.
COUNTIES TO WHICH ABOVE CANCER PATIENTS TENDED TO GO FOR HOSPITALIZATION
NEW YORK STATE HEALTH PREPAREDNESS COMMISSION

FIGURE 4

will not conform to State boundaries. This must be taken into consideration in planning for hospital facilities and the planning and development of outflow services for primary and secondary centers. State lines, and even national boundaries in the case of New York State, do not form natural divisions in respect to certain of the services and functions of the medical and health centers.

For example, no plan for New York State that disregards the excellent medical and hospital services available in Montreal would be realistic nor long stand the test of time insofar as the people in northeastern New York State are concerned. New York City, as a regional medical center, must certainly be prepared to meet and serve the needs of southwestern Connecticut and the eastern border of New Jersey. Albany, as a regional center, may be expected to serve part of western Massachusetts and Vermont. Buffalo and Niagara County, on the other hand, will have interchange with Toronto, which is also an excellent medical center. The extent of this interchange is difficult to predict but it is quite possible that the inflow to New York State will offset the outflow of New York State residents to centers outside of New York State. The south central area of New York State will be influenced by Sayre, Pennsylvania, which has good medical services and may well develop as a strong district center for the State of Pennsylvania. Offsetting this, however, there will very likely be quite extensive inflow from northeastern Pennsylvania to other district centers along the southern border of New York.

The inflow and outflow of patients is a factor that can be very little influenced by organization or planning but most certainly must be considered in any realistic estimate of the size and nature of hospital facilities required. Inasmuch as many detailed aspects of regional service are still in a formative stage, it would be quite difficult to foresee the pattern for interstate and international cooperation until many problems of operation and administration within the State have been solved. But the ultimate desirability of such interstate and international cooperation should be kept in mind.

A test of the proposed regions has been made in an analysis of 13,109 cancer patients reported to the New York State Department of Health in 1944, of which 6,773 were reported to have been hospitalized in upstate New York, exclusive of the New York State Institute for the Study of Malignant Diseases in Buffalo. In Figure 4, there are shown the counties from which a significant proportion of these patients traveled outside of the county of residence for hospital services. There also are shown the counties to which the patients tended to go for such services when they left their own counties of residence. It is remarkable that there are few places where patients crossed the proposed regional boundaries. The actual number of patients who crossed the regional lines was only 6 per cent of the total number of patients represented by all of the arrows,[25] and it is possible that a large number of these did so because of the nearby location of tumor clinics.

THE HEALTH SERVICE DISTRICTS

In determining the logical smaller service districts, essentially the same method has been employed, that is to say, the natural flow of population to trade centers has been followed as presented in Figure 2. It should be pointed out, however, that the following suggestions with respect to the smaller health service districts are regarded as entirely tentative. Planning at a State level without particularized information with regard to local problems and situations should not be definitive.

Figure 5 shows the distribution of the health service districts within the larger regions already described. In this map the health service districts are defined along the lines of county boundaries. Figure 6, on the other hand, shows these health service districts within the same five regions but defined along the lines of the township boundaries used in establishing the trade areas indicated by the marketing study. The choice between defining the health service districts on county or township lines is a matter that requires further study. It will most likely be determined in the end by administrative considerations.

Since definition along township lines is more sensitive to actual population trends, it may represent the more desirable plan in a theoretical sense, both from the point of view of reflecting the direction in which the population would tend to go in seeking hospital and health center services and the direction which the outflow functions of the district hospitals and local health centers might most readily take. The inflow of patients to these hospitals and centers is likely to follow this pattern regardless of where the arbitrary boundaries are drawn. Certainly the administrative functions of the health service districts, to the extent that financial participation by localities is likely to be involved, will have to follow the lines of accepted political subdivisions, and there should be as much uniformity as possible between the location of the administrative units in health services and those of other related public undertakings.

The health service districts may be expected to vary greatly in size and in the nature and extent of the self-contained services and facilities which they provide. For example, a health service district including one of the large urban centers may be expected to provide nearly all of the services and facilities that will be required and its affiliation with the regional center might be largely for academic purposes. In

[25] A total of 712 of the cases of cancer reported in 1944 from the 26 counties shown in Figure 3 were hospitalized outside of the county of residence. The arrows indicate only those counties to which a relatively large proportion of the patients went for hospitalization. The actual number of cases represented by all arrows is 559, or 79 per cent, of the total of 712 patients hospitalized outside of the county of residence.

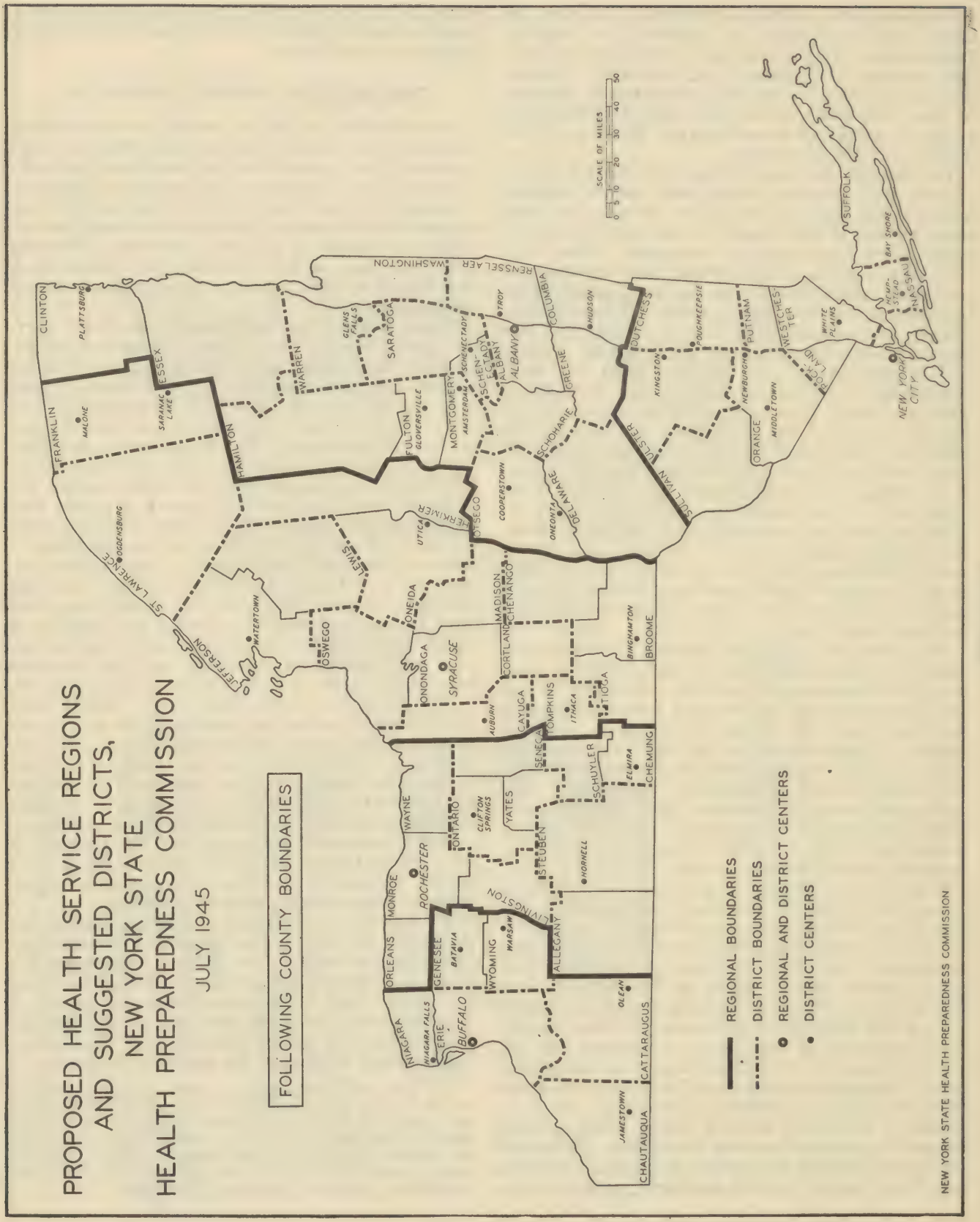

PROPOSED HEALTH SERVICE REGIONS
AND SUGGESTED DISTRICTS,
NEW YORK STATE
HEALTH PREPAREDNESS COMMISSION
JULY 1945
FOLLOWING COUNTY BOUNDARIES
REGIONAL BOUNDARIES
DISTRICT BOUNDARIES
REGIONAL AND DISTRICT CENTERS
DISTRICT CENTERS
SCALE OF MILES
NEW YORK STATE HEALTH PREPAREDNESS COMMISSION

FIGURE 5

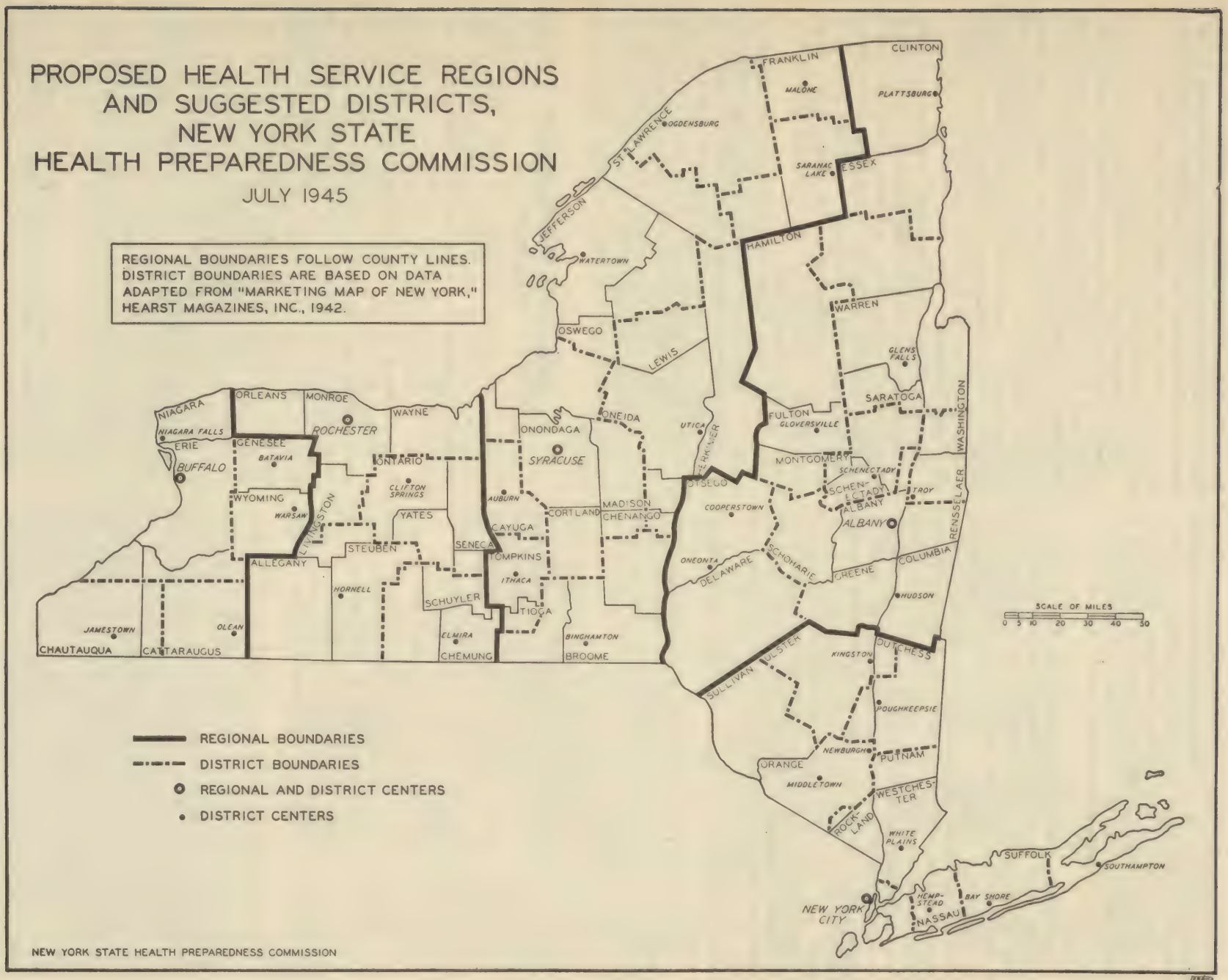

PROPOSED HEALTH SERVICE REGIONS
AND SUGGESTED DISTRICTS,
NEW YORK STATE
HEALTH PREPAREDNESS COMMISSION
JULY 1945
REGIONAL BOUNDARIES FOLLOW COUNTY LINES.
DISTRICT BOUNDARIES ARE BASED ON DATA
ADAPTED FROM "MARKETING MAP OF NEW YORK,"
HEARST MAGAZINES, INC., 1942.
FRANKLIN
CLINTON
MALONE
PLATTSBURG
ST. LAWRENCE
OGDENSBURG
SARANAC LAKE
ESSEX
JEFFERSON
WATERTOWN
HAMILTON
WARREN
OSWEGO
LEWIS
GLENS FALLS
SARATOGA
WASHINGTON
NIAGARA
ORLEANS
MONROE
WAYNE
ONONDAGA
ONEIDA
UTICA
MOHAWK
FULTON
GLOVERSVILLE
NIAGARA FALLS
ROCHESTER
ERIE
GENESEE
BATAVIA
BUFFALO
ONTARIO
SYRACUSE
MONTGOMERY
SCHENECTADY
SCHEN-ECTADY
TROY
OTSEGO
COOPERSTOWN
ALBANY
WYOMING
WARSAW
CLIFTON SPRINGS
AUBURN
MADISON
CORTLAND
CHENANGO
LIVINGSTON
YATES
CAYUGA
RENSSELAER
STEUBEN
SENECA
TOMPKINS
ONEONTA
DELAWARE
SCHOHARIE
GREENE
COLUMBIA
ALLEGANY
ITHACA
HUDSON
HORNELL
SCHUYLER
TIOGA
JAMESTOWN
OLEAN
ELMIRA
BINGHAMTON
CHAUTAUQUA
CATTARAUGUS
CHEMUNG
BROOME
SCALE OF MILES
0 5 10 20 30 40 50
SULLIVAN
ULSTER
KINGSTON
DUTCHESS
POUGHKEEPSIE
NEWBURGH
PUTNAM
ORANGE
MIDDLETOWN
WESTCHESTER
ROCKLAND
WHITE PLAINS
SUFFOLK
SOUTHAMPTON
NEW YORK CITY
HEMPSTEAD
BAY SHORE
NASSAU
REGIONAL BOUNDARIES
DISTRICT BOUNDARIES
REGIONAL AND DISTRICT CENTERS
DISTRICT CENTERS
NEW YORK STATE HEALTH PREPAREDNESS COMMISSION

FIGURE 6

other respects the inflow and outflow functions of the district center in one of the larger districts would be quite similar to those of the regional center. In fact, the district centers may, in some instances, serve many of the functions of a regional center for a part of a health service region. Examples of locations where this may be expected to apply are Utica and Binghamton.

Conversely, some of the more rural health service districts may be centered about a small community hospital and local health center where the provision of facilities for the handling of a complex diagnostic or therapeutic problem would not be practicable. Such a rural center, particularly in a poor or sparsely populated area, will not encounter problems of a complicated nature frequently enough to justify expensive facilities that will be little used; nor will it provide sufficient material to attract and support the services of a specialist. Yet the limitations on the facilities of a rural center are not uniform, as in some cases they will reflect the influence of special factors such as endowment funds, the enterprise of a particular physician or group of physicians, and the wealth of the population served. In such cases, however, these centers must draw patients from an area that is larger than they would normally be expected to serve.

It will be noted that in several of the districts more than one district center is suggested. This was done because of the possibility in these districts that some of the functions of a center might be allocated to hospitals in more than one locality.

In general, the centers of the districts would provide administrative and supplemental services for the smaller or less strategically located hospitals and health centers. The regional centers also would provide district center services in their own immediate vicinities. That is to say, they would receive all types of cases and perform general as well as specialized service functions.

New York City is entirely self-contained. It constitutes an entire region and, in addition, provides the regional center services for metropolitan New York. When fully organized, it will undoubtedly embrace a number of districts or district centers within the metropolitan area. It also serves as the regional center for the southeastern portion of the State.

As has been pointed out, the suggested health service districts are entirely tentative, not only because of the uncertainty as to whether they should be defined along county or township boundaries, but also because it is difficult to foresee in detail the situations that will arise with respect to them. Determination of the district lines will be greatly influenced by the presence and competence of existing facilities. Some of the districts that comprise one unit geographically and functionally may embrace more than one established hospital and health center of approximately equal status. Or, it may happen that a hospital located outside of the natural district center will actually be stronger than the one in the district center and will pull patients away from it. These and other considerations of a similar nature make it extremely difficult and unwise to attempt to outline the smaller districts as definitely as has been done in the case of the larger regions.

The determination of the boundaries of the districts and the details of their functions must be based upon study and trial application to particular needs and purposes. It is quite possible that these districts may have to be somewhat different for various programs, at least during the early years of planning and development. In order that they may eventually be unified, it will be desirable in defining these districts to make provision for flexibility and revision as experience may indicate.

However, there is also some risk in planning on the foundation of too detailed information. In an ideal sense, a plan for providing medical and health service facilities should be developed in response to the needs of the population as a whole and should not be unduly subjected to the influences of one group, or of pressure for an expansion of some existing unit simply because it is already there.

Planning which takes its origin from an extensive survey is quite certain to be beset with this difficulty. In order to avoid this danger, it might be desirable to formulate the fundamental plan as objectively as possible on the basis of what is needed, to expose it to the test of what is already available, as learned by a survey, and then to proceed experimentally on a realistic basis, making whatever modifications are necessary for the rational utilization of existing facilities.

SIZE AND POPULATION

REGIONS

New York State, exclusive of New York City, occupies a land area of 47,630 square miles and has a total population of 6,024,147, as recorded in the last Federal census of April 1, 1940.[26]

The area and population of the upstate area is divided among the five regions outlined in Figure 3 as shown in Table 1. The Albany and Syracuse regions comprise almost two-thirds of the total upstate area. Each of these regions is between two and three times the size of the other three regions, because they include the Adirondack area which is large in size but sparsely populated. This is reflected in the relatively small density of the population per square mile in these two regions (Table 1.) The total population is largest in the New York region with 1,654,050 persons recorded in the 1940 census. The smallest populations, however, 865,972 in the Rochester region and 991,394 in the Albany region, are more than sufficient to support an active and complete medical center.

[26] Although there are known to have been shifts of the population both within the State and from outside the State to war industry centers since that time, there is insufficient information available to indicate the exact nature of these shifts or their permanent effects. Therefore, the 1940 census is considered the most representative data available for use in long range planning at the present time and is used throughout this report.

TABLE 1. *Distribution of Population, Land Area and Population Per Square Mile, by Health Service Regions Proposed for New York State, Exclusive of New York City, 1940*

REGION	Population			Land Area (Sq. Miles)	Population Per Square Mile
	Total	Male	Female		
Total, New York State (exclusive of New York City)	6,024,147	3,014,033	3,010,114	47,630	126
Albany	991,394	497,512	493,882	13,881	71
Buffalo	1,230,594	616,948	613,646	5,101	241
New York (exclusive of New York City)	1,654,050	823,929	830,121	5,844	283
Rochester	865,972	431,419	434,553	6,836	127
Syracuse	1,282,137	644,225	637,912	15,968	80

TABLE 2. *Age Distribution of Population in Each Health Service Region, New York State Exclusive of New York City, 1940*

REGION	Age (Years)				Per Cent			
	Total	Under 30	30–59	60 and Over	Total	Under 30	30–59	60 and Over
Total, New York State (exclusive of N. Y. C.)	6,024,147	2,802,926	2,458,209	763,012	100.0	46.5	40.8	12.7
Albany	991,394	449,542	400,253	141,599	100.0	45.3	40.4	14.3
Buffalo	1,230,594	595,850	497,340	137,404	100.0	48.4	40.4	11.2
New York (exclusive of N. Y. C.)	1,654,050	750,698	716,192	187,160	100.0	45.4	43.3	11.3
Rochester	865,972	397,481	347,737	120,754	100.0	45.9	40.2	13.9
Syracuse	1,282,137	609,355	496,687	176,095	100.0	47.5	38.7	13.7

TABLE 3. *Proportion of the Population in Each Health Service Region Residing in Urban and Rural Areas, New York State, Exclusive of New York City, 1940*

REGION	Population			Per Cent		
	Total	Urban	Rural	Total	Urban	Rural
Total, New York State (exclusive of N. Y. C.)	6,024,147	3,710,898	2,313,249	100.0	61.6	38.4
Albany	991,394	568,279	423,115	100.0	57.3	42.7
Buffalo	1,230,594	927,767	302,827	100.0	75.4	24.6
New York (exclusive of N. Y. C.)	1,654,050	909,446	744,604	100.0	55.0	45.0
Rochester	865,972	538,644	327,328	100.0	62.2	37.8
Syracuse	1,282,137	766,762	515,375	100.0	59.8	40.2

The variations in the age and sex distribution of the population in the five regions are not marked, as shown in Tables 1 and 2, except for the fact that slightly smaller proportions of the total populations in the Buffalo and New York regions are 60 years of age and over.

The percentages of the population classified, in the 1940 census, as residing in urban and rural areas[27] are similar in the Albany, Rochester and Syracuse areas (Table 3). In the Buffalo region, however, the proportion of the population reported as rural is much smaller than in the other regions. The highest proportion classified as rural is in the New York region exclusive of New York City, but this is not considered comparable to the data for other regions because of the large number of unincorporated communities in the Greater New York Area which are classified as rural by the United States Census Bureau, but usually are not considered rural because they are suburban to New York City.

[27] An urban area is defined by the United States Census Bureau as a city or other incorporated place having 2,500 or more inhabitants. All other areas are classified as rural.

In summary, it may be stated that the three regions served by the regional centers of Albany, Rochester, and Syracuse are for the most part similar in respect to population characteristics as reported in the 1940 census. The Buffalo and New York regions, on the other hand, have comparatively larger numbers of persons per square mile, smaller areas, and somewhat smaller proportions of the population in the group 60 years of age and over than do the other regions. The Buffalo region also has an appreciably smaller proportion of its population in rural areas than do the Albany, Rochester, and Syracuse regions.

DISTRICTS

The area and population of the 28 districts, into which the five upstate regions are subdivided, and data relating to the age, sex, and urban composition of the population of each district are shown in Appendix B, Tables I through IV. These tabulations include data for the districts which follow county boundaries as shown in Figure 5. Available data for districts which follow township boundaries, Figure 6, have been compiled but are not included in this report since, as previously stated, those following county boundaries may be of more immediate practical use than the districts shown in Figure 6. For the most part, however, the population characteristics of the districts are not materially affected by changing the boundaries of the districts shown in Figure 5 to those shown in Figure 6.

The tentative districts shown in Figure 5 vary a great deal in respect to size and population (Appendix B). Whether or not there is an optimum size for areas or populations served by district centers remains to be determined, but there are certain fixed factors such as natural boundaries and transportation facilities which must be taken into consideration in dividing the regions into districts, and it is believed that distribution of medical and hospital facilities within each district may be adjusted accordingly. The smallest population assigned to any district shown in Figure 5 is 42,340; the largest, exclusive of New York City, is 958,487. Eight districts have populations of over 200,000; eight districts have populations of between 100,000 and 200,000; and 12 districts have population of less than 100,000. The largest populations are in the districts including the larger urban areas and those adjacent to New York City. The land area of the districts ranges from 300 square miles in the Hempstead district of the New York region to 3,117 square miles in the Albany-Hudson-Troy district of the Albany region. The average size is 1,650 square miles. Except for the Adirondack area, the longest distance from any point within a district to the district center is 45 or 50 miles, with the majority of the points in the district much closer.

EXISTING HOSPITAL AND MEDICAL FACILITIES

NUMBER OF HOSPITALS AND BED CAPACITY

Tabulations have been prepared to show the existing general hospital facilities in each of the regions and districts shown in Figure 5. For purposes of comparison, these tabulations have been limited to general hospitals and special hospitals providing services ordinarily considered as a part of those of general hospitals serving local communities, such as: ear, nose and throat; maternity; isolation and communicable disease; pediatric; and industrial. State and Federally operated hospitals, convalescent hospitals, hospitals classed as orthopedic, country branches of New York City hospitals, and hospitals operated by private organizations for the benefit of their members are not included because they usually serve larger areas than the district in which they are located, and therefore cannot be properly related to the population of that district.

As shown in Table 4, there are in New York State, exclusive of New York City, 281 hospitals classified as general or special of the types listed above. The total bed capacity of these hospitals is 23,182, or one bed per 255 of the population (3.9 beds per 1,000 population). Approximately one-third of the hospitals have less than 25 beds; slightly less than one-third have bed capacities of over 100, as shown in Table 5. The Albany and Syracuse districts, as might be expected because of the sparse population and inconvenience of travel in the Adirondack area, have comparatively larger proportions of hospitals of less than 25 beds and smaller proportions of hospitals with bed capacities of 100 and over than do the other three regions.

The average ratio of general hospital beds to population ranges from one bed to 237 of the population (4.2 beds per 1,000 population), in the Rochester and Syracuse regions, respectively, to one bed to 283 of the population (3.5 beds per 1,000 population), in the New York region exclusive of New York City. An analysis of hospital facilities in the New York region, however, should not be made without taking into consideration the facilities in New York City. The number of hospitals and hospital beds in New York City is included in Table 4 for this purpose. When the New York City population and facilities are added to those in the region exclusive of New York City, the ratio of hospital beds to population in the New York region is reduced to one bed per 215 of the population (4.6 beds per 1,000 population). However, the true ratio of available beds to population in this region probably is somewhere between the two figures of 215 and 283 (4.6 to 3.5 beds per 1,000 population), since it is known that the New York City hospitals serve areas other than

TABLE 4. *Number of General and Allied Special Hospitals, Total Bed Capacity, and Population Per Hospital Bed in Each Health Service Region and District Shown in Figure 5, New York State, and New York State, Exclusive of New York City, 1944*

REGIONS AND DISTRICTS	Population [1]	Hospitals		Ratio of Population to Hospital Beds	
		Number [2]	Bed Capacity	Population Per Hospital Bed	Beds Per 1,000 Population
New York State	13,365,608	410	59,608	224	4.5
New York City	7,444,146	129	36,426	204	4.9
New York State (exclusive of New York City)	5,921,462	281	23,182	255	3.9
Albany region	985,803	57	3,693	267	3.7
Districts:					
Albany-Hudson-Troy	432,965	18	1,801	240	4.2
Amsterdam-Gloversville	111,927	3	372	301	3.3
Cooperstown-Oneonta	86,852	15	338	257	3.9
Glens Falls	81,304	6	248	328	3.0
Plattsburgh	84,655	9	315	269	3.7
Schenectady	188,100	6	619	304	3.2
Buffalo region	1,223,334	45	4,908	249	4.0
Districts:					
Batavia-Warsaw	73,351	5	263	279	3.6
Buffalo-Niagara Falls	953,751	27	3,951	241	4.1
Jamestown	123,580	6	403	307	3.2
Olean	72,652	7	291	250	4.0
New York region (exclusive of New York City)	1,596,115	66	5,644	283	3.5
Districts:					
Bay Shore	173,173	10	503	344	2.9
Hempstead	406,748	11	882	461	2.2
Kingston	85,588	5	220	389	2.6
Middletown-Newburgh	174,115	14	691	252	4.0
Poughkeepsie	105,364	4	396	266	3.8
White Plains	651,127	22	2,952	221	4.5
New York City	7,444,146	129	36,426	204	4.9
New York region (inclusive of New York City)	9,040,261	195	42,070	215	4.6
Rochester region	850,274	35	3,595	237	4.2
Districts:					
Clifton Springs	93,269	6	602	155	6.4
Elmira	85,027	3	472	180	5.5
Hornell	122,964	8	422	291	3.4
Rochester	549,014	18	2,099	262	3.8
Syracuse region	1,265,936	78	5,342	237	4.2
Districts:					
Auburn	63,842	3	302	211	4.8
Binghamton	226,309	15	1,231	184	5.4
Ithaca	42,139	3	172	245	4.1
Malone-Saranac Lake	43,867	3	162	271	3.7
Ogdensburg	88,995	8	335	266	3.8
Syracuse	438,610	22	1,654	265	3.8
Utica	255,356	12	1,050	243	4.1
Watertown	106,818	12	436	245	4.1

NOTE: There are included only the general and special hospitals reported to provide the following types of services: general, ENT, industrial, maternity isolation, communicable disease, and pediatric. State and Federal hospitals are excluded. Also excluded are hospitals for tuberculosis, nervous and mental orthopedic, chronic and incurable; infirmaries of institutions; convalescent hospitals and homes; country branches of New York City hospitals; and hospitals operated by private organizations for the benefit of their members.

[1] 1940 census population exclusive of estimated population of Federal and State hospitals and institutions.

[2] Taken from list of facilities compiled by the New York State Health Preparedness Commission from the following sources:

a. "The 1944 Census of Hospitals," *The Journal of the American Medical Association*, March 31, 1945.

b. "Twenty-Seventh Annual Hospital Standardization Survey" (including list of approved hospitals in the United States, Canada and other countries as of December 31, 1944), *Bulletin of the American College of Surgeons*, December, 1944.

c. New York State Department of Social Welfare, *Directory of Hospitals and Dispensaries*, 1942.

d. Unincorporated maternity homes licensed by the New York State Department of Health, 1944.

TABLE 5. *Number of Hospitals According to Size, in Each Health Service Region and District Shown in Figure 5, New York State, Exclusive of New York City, 1944*

REGION AND DISTRICT	Number of Hospitals					
		Size of hospitals (bed capacity)				
	Total [1]	Less Than 25	25–49	50–74	75–99	100 and Over
New York State (exclusive of New York City)	281	97	43	32	26	83
Albany region	57	27	7	6	3	14
Districts:						
Albany-Hudson-Troy	18	6	1	4	..	7
Amsterdam-Gloversville	3	..	..	..	..	3
Cooperstown-Oneonta	15	10	3	1	1	..
Glens Falls	6	4	..	..	..	2
Plattsburgh	9	6	1	..	1	1
Schenectady	6	1	2	1	1	1
Buffalo region	45	11	8	6	2	18
Districts:						
Batavia-Warsaw	5	2	..	2	..	1
Buffalo-Niagara Falls	27	4	5	4	1	13
Jamestown	6	2	1	..	..	3
Olean	7	3	2	..	1	1
New York region (exclusive of New York City)	66	17	10	10	8	21
Districts:						
Bay Shore	10	3	3	1	2	1
Hempstead	11	5	..	2	..	4
Kingston	5	3	..	..	1	1
Middletown-Newburgh	14	4	4	4	1	1
Poughkeepsie	4	..	1	1	..	2
White Plains	22	2	2	2	4	12
Rochester region	35	7	11	3	2	12
Districts:						
Clifton Springs	6	..	2	1	1	2
Elmira	3	..	1	..	..	2
Hornell	8	2	2	2	..	2
Rochester	18	5	6	..	1	6
Syracuse region	78	35	7	7	11	18
Districts:						
Auburn	3	1	..	..	1	1
Binghamton	15	9	..	1	3	2
Ithaca	3	2	..	..	..	1
Malone-Saranac Lake	3	..	1	1	1	..
Ogdensburg	8	4	2	1	..	1
Syracuse	22	9	2	2	3	6
Utica	12	2	..	2	3	5
Watertown	12	8	2	..	..	2

[1] There are included only the general and special hospitals reported to provide the following types of services: general, ENT, industrial, maternity, isolation, communicable disease, and pediatric. State and Federal hospitals are excluded. Also excluded are hospitals for tuberculosis, nervous and mental, orthopedic, chronic and incurable; infirmaries of institutions; convalescent hospitals and homes; country branches of New York City hospitals; and hospitals operated by private organizations for the benefit of their members.

New York City and the New York City region. They probably do so to a greater extent than do the other major medical centers in the State.

The usually accepted standard of one general hospital bed for each 225 to 250 of the population (4.0 to 4.5 beds per 1,000 population), is met in all but the Albany region and the New York region, exclusive of New York City. The ratio of general hospital beds to deaths from all causes is sometimes suggested as an index of the need for general hospital beds and is presented for each region in Table 6. The Albany and New York regions, exclusive of New York City, also are shown to have fewer beds in relation to the need when measured on this basis than do the other three regions, but the difference is not so marked in the New York region, exclusive of New York City, and is more marked in the Albany region than when measured by the ratio of beds to the total population.

There does not seem to be any uniform pattern for the present distribution of hospital beds in relation to the population in the districts (Table 4). In the Albany and Buffalo regions, there are more beds in relation to the size of the population in the districts including the regional centers than in the other districts in the same regions. This same pattern is not found in the Rochester region where there are relatively fewer beds in the district, including Rochester City, than in the Clifton Springs and Elmira districts; nor is it true in the Syracuse region where there are 265 persons per hospital bed (3.8 beds per 1,000 population), in the Syracuse district, as compared with a range of 184 to 245 persons (5.4 to 4.1 beds per 1,000 population), in five other districts in the same region, namely, Binghamton, Auburn, Utica, Ithaca, and Watertown. Some variation is entirely reasonable and to be expected, but study of each individual district and the factors involved would be required to indicate those which are justifiable and in accordance with an orderly plan for hospital services. Table V in Appendix B presents basic data relating to the size, population, number of hospitals, and number of hospital beds in each county for purposes of further study and analysis.

TABLE 6. *General Hospital Bed Capacity, Number of Deaths from all Causes Exclusive of Tuberculosis, and Ratio of Deaths to Beds in Each Health Service Region, New York State, Exclusive of New York City, 1944*

HEALTH SERVICE REGIONS	General Hospital Bed Capacity	Number of Deaths From All Causes Exclusive of Tuberculosis [1]	Number of Deaths Per Bed
New York State (exclusive of New York City)	23,182	68,354	2.9
Albany	3,693	12,673	3.4
Buffalo	4,908	13,444	2.7
New York (exclusive of New York City)	5,644	16,976	3.0
(New York, inclusive of New York City)	(42,070)	(94,087)	(2.2)
Rochester	3,595	9,941	2.8
Syracuse	5,342	15,320	2.9

[1] Allocated to place of residence, exclusive of deaths in Federal and State institutions.

HOSPITAL REGISTRATION AND APPROVAL

Of the 281 general and allied special hospitals included in the tabulations, 202, or 72 per cent, are registered by the American Medical Association and 135, or 48 per cent, are approved either fully or provisionally[28] by the American College of Surgeons. Excluding hospitals with less than 25 beds which are not eligible for approval by the American College of Surgeons, the percentage of hospitals approved by the American College of Surgeons is increased to 73 per cent.

[28] Defined as follows: the hospital has accepted the requirements and is endeavoring to put them into effect, but for lack of time or other acceptable reasons has not been able to do so in every detail; or the hospital was failing at the time of the last survey to comply sufficiently with the requirements to merit full approval.

Another indication of the extent to which accepted standards of hospital care are met is the number of beds, rather than the actual number of hospitals, registered by the American Medical Association and approved by the American College of Surgeons, as shown in Table 7. The percentage of beds in hospitals approved by the American College of Surgeons, as presented in this table, is computed on the basis of the number of beds in all hospitals rather than on the basis of the number of beds in hospitals of 25 beds and over, because the statement by the American College of Surgeons, "The College does not consider that a hospital of less than 25 beds is usually justified, since it is difficult for institutions so small to provide the essential equipment and to attract competent personnel," seems to indicate blanket disapproval of hospitals of less than 25 beds.

TABLE 7. *Percentage of Hospital Bed Capacity in Each Health Service Region and District Shown in Table 4, Registered by the American Medical Association and Approved by the American College of Surgeons, New York State, Exclusive of New York City, 1944*

REGION AND DISTRICT	Number of Hospitals			Bed Capacity [1]			Per Cent of Hospital Bed Capacity	
	All Hospitals	Registered by American Medical Association [2]	Approved by American College of Surgeons [3]	All Hospitals	Registered by American Medical Association [2]	Approved by American College of Surgeons [3]	Registered by American Medical Association	Approved by American College of Surgeons
New York State (exclusive of New York City)	281	202	135	23,182	22,157	19,485	95.6	84.1
Albany region	57	40	22	3,693	3,597	3,080	97.4	83.4
Districts:								
Albany-Hudson-Troy	18	14	10	1,801	1,773	1,641	98.4	91.1
Amsterdam-Gloversville	3	3	3	372	372	372	100.0	100.0
Cooperstown-Oneonta	15	7	1	338	291	95	86.1	28.1
Glens Falls	6	3	2	248	236	220	95.2	88.7
Plattsburgh	9	7	4	315	306	262	97.1	83.2
Schenectady	6	6	2	619	619	490	100.0	79.2
Buffalo region	45	33	19	4,908	4,697	3,810	95.7	77.6
Districts:								
Batavia-Warsaw	5	3	3	263	260	260	98.9	98.9
Buffalo-Niagara Falls	27	21	12	3,951	3,791	3,139	96.0	79.4
Jamestown	6	4	2	403	360	226	89.3	56.1
Olean	7	5	2	291	286	185	98.3	63.6
New York region (exclusive of New York City)	66	51	39	5,644	5,289	4,883	93.7	86.5
Districts:								
Bay Shore	10	7	4	503	461	335	91.7	66.6
Hempstead	11	6	6	882	809	809	91.7	91.7
Kingston	5	3	2	220	212	194	96.4	88.2
Middletown-Newburgh	14	11	7	691	483	528	69.9	76.4
Poughkeepsie	4	4	3	396	396	346	100.0	87.4
White Plains	22	20	17	2,952	2,928	2,671	99.2	90.5
Rochester region	35	32	21	3,595	3,525	3,263	98.1	90.8
Districts:								
Clifton Springs	6	6	4	602	602	547	100.0	90.9
Elmira	3	3	2	472	472	436	100.0	92.4
Hornell	8	8	6	422	422	391	100.0	92.7
Rochester	18	15	9	2,099	2,029	1,889	96.7	90.0
Syracuse region	78	46	34	5,342	5,049	4,449	95.4	83.3
Districts:								
Auburn	3	2	2	302	299	299	99.0	99.0
Binghamton	15	8	6	1,231	1,168	1,135	94.9	92.2
Ithaca	3	1	1	172	147	147	85.5	85.5
Malone-Saranac Lake	3	3	2	162	162	132	100.0	81.5
Ogdensburg	8	3	4	335	252	301	75.2	89.9
Syracuse	22	16	9	1,654	1,632	1,360	98.7	82.2
Utica	12	10	7	1,050	1,046	732	99.6	69.7
Watertown	12	3	3	436	343	343	78.7	78.7

[1] There are included only the general and special hospitals reported to provide the following types of services: general, ENT, industrial, maternity, isolation, communicable disease, and pediatric. State and Federal hospitals are excluded. Also excluded are hospitals for tuberculosis, nervous and mental, orthopedic, chronic and incurable; infirmaries of institutions; convalescent hospitals and homes; country branches of New York City hospitals; and hospitals operated by private organizations for the benefit of their members.

[2] "The 1944 Census of Hospitals," *Journal of American Medical Association*, March 31, 1945.

[3] "Twenty-Seventh Annual Hospital Standardization Survey," *Bulletin of the American College of Surgeons*, December, 1944. Approval granted only to hospitals of 25 beds and over.

TABLE 8. *Number of Physicians, Number of Specialists, Ratio of Physicians to Population and Ratio of Physicians in Health Service Regions and Districts Shown in Figure 5, New York State, Exclusive of New York City, 1944*

REGIONS AND DISTRICTS	Population [1]	Number of Physicians [2]	Population per Physician	Number of Specialists [3]	Number Physicians per Specialist
New York State (exclusive of New York City)	5,921,462	8,032	737	1,260	6.4
Albany region	985,803	1,196	824	186	6.4
Districts:					
Albany-Hudson-Troy	432,965	580	746	112	....
Amsterdam-Gloversville	111,927	126	888	11	....
Cooperstown-Oneonta	86,852	92	944	14	....
Glens Falls	81,304	99	821	11	....
Plattsburgh	84,655	76	1,114	2	....
Schenectady	188,100	223	843	36	....
Buffalo region	1,223,334	1,577	776	255	6.2
Districts:					
Batavia-Warsaw	73,351	73	1,005	4	....
Buffalo-Niagara Falls	953,751	1,325	720	228	....
Jamestown	123,580	113	1,094	18	....
Olean	72,652	66	1,101	5	....
New York region (exclusive of New York City)	1,596,115	2,610	612	313	8.3
Districts:					
Bay Shore	173,173	263 [4]	658	16	....
Hempstead	406,748	656 [4]	620	65	....
Kingston	85,588	77	1,112	9	....
Middletown-Newburgh	174,115	190	916	30	....
Poughkeepsie	105,364	165	639	19	....
White Plains	651,127	1,259 [4]	517	174	....
Rochester region	850,274	1,168	728	205	5.7
Districts:					
Clifton Springs	93,269	113	825	27	....
Elmira	85,027	92	924	13	....
Hornell	122,964	114	1,079	4	....
Rochester	549,014	849	647	161	....
Syracuse region	1,265,936	1,481	855	301	4.9
Districts:					
Auburn	63,842	72	887	10	....
Binghamton	226,309	262	864	56	....
Ithaca	42,139	62	680	22	....
Malone-Saranac Lake	43,867	52	844	8	....
Ogdensburg	88,995	77	1,156	6	....
Syracuse	438,610	536	818	144	....
Utica	255,356	312	818	38	....
Watertown	106,818	108	989	17	....

[1] 1940 census population exclusive of estimated population of Federal and State institutions.

[2] Includes physicians in military service, but excludes physicians in full-time positions in Federal and State institutions, public health, and physicians retired or not engaged in practice at time of November 1, 1944 survey of the New York State Department of Health.

[3] Certified as Diplomates of the American Boards or applications approved for specialist consultation service in Department of Health Emergency, Maternity, and Infant Care and Medical Rehabilitation programs.

[4] Information on number of physicians in other than active practice not available for Nassau, Suffolk, and Westchester Counties. The data included in this table for these Counties was compiled from the 1941–1942 Medical Directory of New York State.

Ninety-six per cent of the beds in the upstate area are in hospitals registered by the American Medical Association and 85 per cent are in hospitals approved by the American College of Surgeons. The percentages of the total beds in hospitals registered by the American Medical Association closely approximates the average in each region with somewhat wider variations in the districts into which the regions are divided. The percentages in hospitals approved by the American College of Surgeons, however, varies from 77.6 per cent in the Buffalo region to 91.1 per cent in the Albany region. In 23 of the 28 districts, at least 75 per cent of the beds are in hospitals either fully or provisionally approved, but in one district, only 28 per cent of the beds are in hospitals approved by the American College of Surgeons. Furthermore, there are some areas of the State, notably the Adirondack section, where approved hospital facilities are not reasonably accessible.

The existence of a significant number of beds and institutions, although they constitute only a small proportion of the whole, not meeting minimal standards in New York State, which is relatively wealthy and well provided with means for securing adequate facilities, is a matter that merits immediate consideration. It suggests the need of review of procedures and laws relating to hospitals, and presents an opportunity for the development of cooperative relationships and the strengthening of services that should result from a regionalized system.

PHYSICIANS

Table 8 shows the number of physicians in active practice in New York State, exclusive of New York City, Nassau, Suffolk, and Westchester Counties, as compiled from a survey by the New York State Department of Health in 1944. The tabulation includes physicians reported to have been in military service at that time, who might be expected to return to active practice, but excludes those in full-time positions in public health and Federal and State institutions. Insofar as possible, comparable data have been obtained from the 1941–42 Medical Director for Nassau, Suffolk and Westchester Counties for which information could not be obtained in the New York State Department of Health Survey.

Table 8 also presents data as to the number of specialists in each region and district, including those certified as Diplomates of the fifteen American Boards and those who have submitted applications and have been approved as specialists in connection with services administered by the New York State Department of Health, such as the Federal Emergency, Maternity, and Infant Care and Medical Rehabilitation programs.[29]

[29] Includes those Diplomates included in the Third Edition of the Directory of Medical Specialists and Intermistic Supplements numbers one and two; the specialists approved by the New York State Department of Health is limited to those who are in fields related to the programs of the Department; therefore, the list is known to be incomplete in that it does not include physicians engaged in every type of specialty practice.

In the State, exclusive of New York City, there is an average of one physician in private practice for every 737 persons. The ratio of physicians to the population in each of the regions is as follows: New York, exclusive of New York City, 1:612; Rochester, 1:728; Buffalo, 1:776; Albany, 1:824; and Syracuse, 1:855. One out of approximately six physicians in the State, exclusive of New York City, is classified as a specialist, as defined above. In general, the New York region, which has the largest number of physicians in relation to its population, also has the highest proportion of its physicians classified as specialists, whereas the Syracuse region with the smallest number of physicians in relation to its population also has the smallest proportion of its physicians classified as specialists.

The ratio of physicians to population in each district ranges from 1 physician to 517 of the population in the White Plains District to 1 to 1,156 in the Ogdensburg District. Compared to the Nation as a unit and to its various component states, these ratios seem favorable. Taken in its entirety, New York State is reported to be receiving its share of new physicians entering in practice. However, the United States Public Health Service has indicated the uncertainties in the use of numerical counts as a measure of physician resources. Other factors such as the age of a physician and the concentration of the population, which limit the case load he is able to handle, must be considered and evaluated. The physician resources in each region and district should be studied to determine their sufficiency to provide adequate medical service.

SOME EXISTING PATTERNS OF ADMINISTRATIVE REGIONALIZATION OF HEALTH AND RELATED SERVICES IN NEW YORK STATE (JUNE 1945)

1. NEW YORK STATE DEPARTMENT OF HEALTH

The New York State Department of Health maintains 20 District State Health offices, located in Albany, Amsterdam, Batavia, Binghamton, Buffalo, Geneva, Glens Falls, Gouverneur, Hornell, Ithaca, Jamestown, Kingston, Middletown, New York City, Oneonta, Poughkeepsie, Rochester, Saranac Lake, Syracuse and Utica (Figure 7). Each office serves a district of from two to four counties. The area comprised in each district as well as the location of the district office reflects not only administrative convenience but also various compromises made necessary by limitations in personnel. The functions of the State Department of Health might be better served in some instances by smaller districts. The districts as now constituted follow county boundaries because a great deal of work of the district offices must take into account the county as a unit of government.

2. NEW YORK STATE DEPARTMENT OF SOCIAL WELFARE

For administrative purposes, the Department of Social Welfare has divided the State into five districts or areas, with "area offices" in Buffalo, Rochester, Syracuse, Albany and New York City (Figure 8). These were designed largely on the basis of accessibility with respect to the area office. The five districts or areas thus formed correspond fairly closely to the scheme of regions with respect to health services.

3. NEW YORK STATE DEPARTMENT OF MENTAL HYGIENE

The 18 State mental hospitals, exclusive of those for the epileptic and mentally defective, and the territories which each serves are shown in Figure 9. Although the residents of a few areas may choose from among the two or more hospitals, the districts in upstate New York are generally coterminous. However, application for the hospitalization outside the district of residence may be made to the Commissioner of Mental Hygiene who has the authority to approve such institutionalization. These districts do not in any appreciable way correspond to the health service regions proposed in this report.

4. STATE TUBERCULOSIS HOSPITAL DISTRICTS (NEW YORK STATE DEPARTMENT OF HEALTH)

The four State tuberculosis sanatoria at Mount Morris, Ithaca, Oneonta, and Raybrook, and the counties which each serves are depicted in Figure 10. The counties not included in the districts pertaining to these sanatoria are omitted because they are served by county or municipal sanatoria. For this reason these districts do not necessarily represent natural service areas. They illustrate an adaptation of the regional principle with respect to a special and central health service, even when, for various reasons, the regions do not conform to areas of optimum convenience and accessibility to the center which provides the service.

5. ORTHOPEDIC CLINIC DISTRICTS (NEW YORK STATE DEPARTMENT OF HEATH)

A further example of the need for and acceptance of, the regional or district plan with respect to special health services, is that of the orthopedic clinic services furnished through the Bureau of Medical Rehabilitation of the New York State Department of Health. In June 1945, the State, exclusive of New York City, was served by nine orthopedic surgeons, each of whom conducted clinics in a designated district (Figure 11). The orthopedic districts may be considered self-contained and complete with respect to orthopedic services. However, revision of the districting plan with respect to other services such as plastic surgery, ophthalmologic surgery and neurosurgery, which may come under the responsibility of the Bureau of Medical Rehabilitation, may be necessary because of the scarcity of qualified specialists in these fields.

6. MEDICAL SOCIETY OF THE STATE OF NEW YORK

Since the exigencies of travel made attendance at State-wide meetings difficult for many physicians, the New York State Medical Association in 1884 established District Branches where the physicians of these respective regions might discuss scientific material and keep abreast with the important advances in medicine. These Districts were laid out with due consideration to concentrations of population, convenience of meeting and, in general, followed the boundaries of the Judicial Districts.

When the Association was absorbed by the Medical Society of the State of New York in 1905, the latter retained the concept of the District Branches. Although more Branches have been created in the intervening years, their purpose has remained essentially unchanged. The District Branches, as well as the local county medical societies, have representation in the House of Delegates of the State Medical Society and therefore are definitely an integral part of the state organization, (Figure 12).

7. HOSPITAL ASSOCIATION OF NEW YORK STATE

The Hospital Association of New York State counts among its constituents most of the hospitals in the State. In addition most of them also belong to neighborhood or regional, Hospital Councils. Although the hospitals in some counties are members of more than one council, the adjoining map allocates the respective counties to the territory of the one specific council to which each most logically belongs geographically (Figure 13).

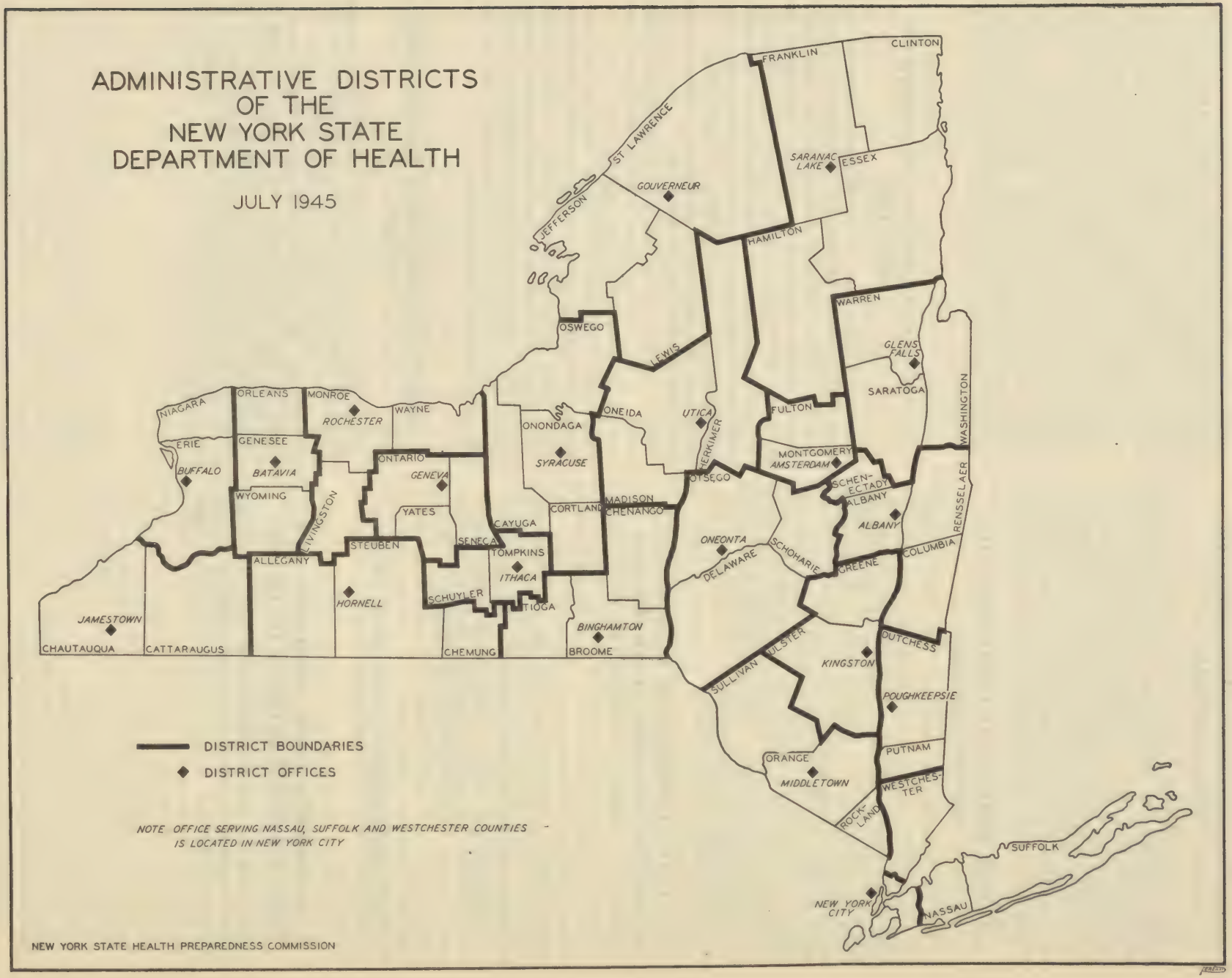

ADMINISTRATIVE DISTRICTS
OF THE
NEW YORK STATE
DEPARTMENT OF HEALTH
JULY 1945
FRANKLIN
CLINTON
ST LAWRENCE
SARANAC LAKE
ESSEX
GOUVERNEUR
JEFFERSON
HAMILTON
WARREN
OSWEGO
LEWIS
GLENS FALLS
SARATOGA
WASHINGTON
NIAGARA
ORLEANS
MONROE
ROCHESTER
WAYNE
ONONDAGA
ONEIDA
UTICA
HERKIMER
FULTON
MONTGOMERY
AMSTERDAM
ERIE
GENESEE
BUFFALO
BATAVIA
ONTARIO
GENEVA
SYRACUSE
OTSEGO
SCHEN-ECTADY
ALBANY
RENSSELAER
WYOMING
LIVINGSTON
YATES
CORTLAND
MADISON
CHENANGO
CAYUGA
SENECA
ONEONTA
SCHOHARIE
COLUMBIA
GREENE
ALLEGANY
STEUBEN
TOMPKINS
ITHACA
DELAWARE
HORNELL
SCHUYLER
TIOGA
BINGHAMTON
JAMESTOWN
CHAUTAUQUA
CATTARAUGUS
CHEMUNG
BROOME
ULSTER
DUTCHESS
KINGSTON
SULLIVAN
POUGHKEEPSIE
PUTNAM
ORANGE
MIDDLETOWN
WESTCHES-TER
ROCK-LAND
SUFFOLK
NEW YORK CITY
NASSAU
DISTRICT BOUNDARIES
DISTRICT OFFICES
NOTE OFFICE SERVING NASSAU, SUFFOLK AND WESTCHESTER COUNTIES IS LOCATED IN NEW YORK CITY
NEW YORK STATE HEALTH PREPAREDNESS COMMISSION

FIGURE 7

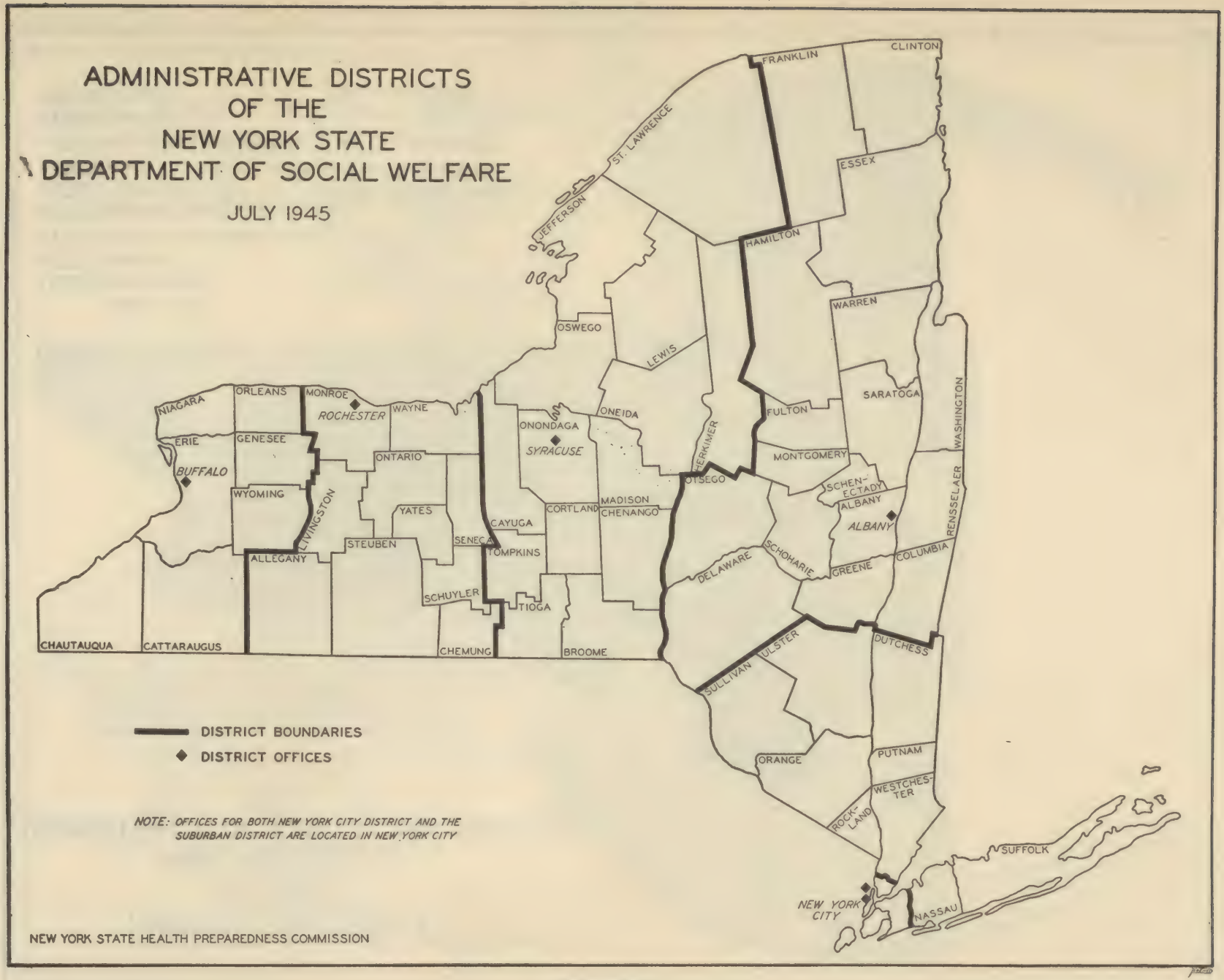

ADMINISTRATIVE DISTRICTS
OF THE
NEW YORK STATE
DEPARTMENT OF SOCIAL WELFARE
JULY 1945
FRANKLIN
CLINTON
ST. LAWRENCE
ESSEX
JEFFERSON
HAMILTON
WARREN
OSWEGO
LEWIS
SARATOGA
WASHINGTON
ONEIDA
FULTON
NIAGARA
ORLEANS
MONROE
ROCHESTER
WAYNE
ONONDAGA
SYRACUSE
HERKIMER
MONTGOMERY
ERIE
GENESEE
ONTARIO
OTSEGO
SCHEN-
ECTADY
BUFFALO
WYOMING
LIVINGSTON
YATES
CORTLAND
MADISON
CHENANGO
ALBANY
RENSSELAER
CAYUGA
SENECA
TOMPKINS
STEUBEN
ALLEGANY
DELAWARE
SCHOHARIE
GREENE
COLUMBIA
SCHUYLER
TIOGA
CHAUTAUQUA
CATTARAUGUS
CHEMUNG
BROOME
SULLIVAN
ULSTER
DUTCHESS
ORANGE
PUTNAM
WESTCHES-
TER
ROCK-
LAND
SUFFOLK
NEW YORK
CITY
NASSAU
DISTRICT BOUNDARIES
DISTRICT OFFICES
NOTE: OFFICES FOR BOTH NEW YORK CITY DISTRICT AND THE SUBURBAN DISTRICT ARE LOCATED IN NEW YORK CITY
NEW YORK STATE HEALTH PREPAREDNESS COMMISSION

FIGURE 8

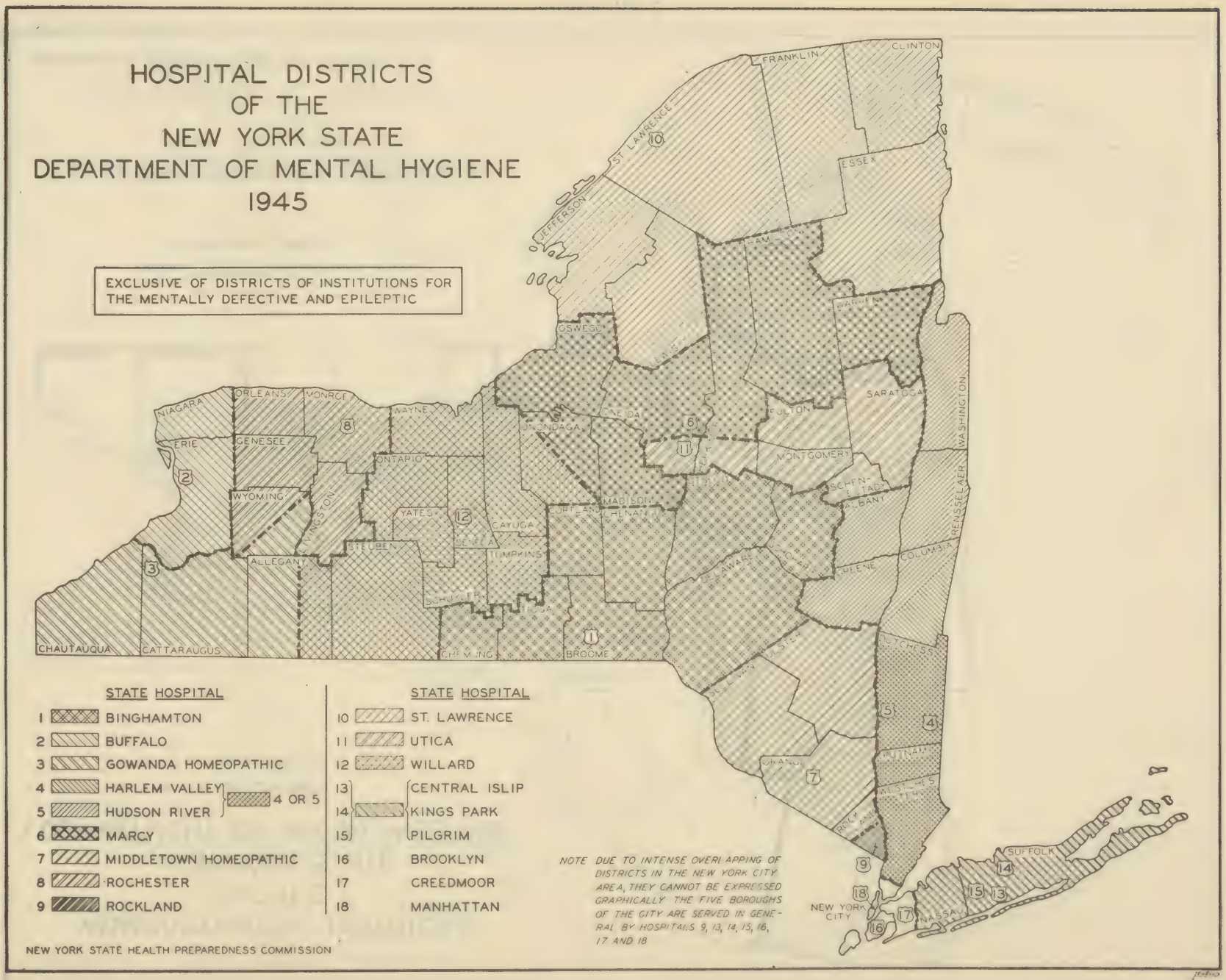

HOSPITAL DISTRICTS
OF THE
NEW YORK STATE
DEPARTMENT OF MENTAL HYGIENE
1945
EXCLUSIVE OF DISTRICTS OF INSTITUTIONS FOR THE MENTALLY DEFECTIVE AND EPILEPTIC
STATE HOSPITAL
1 BINGHAMTON
2 BUFFALO
3 GOWANDA HOMEOPATHIC
4 HARLEM VALLEY
5 HUDSON RIVER
4 OR 5
6 MARCY
7 MIDDLETOWN HOMEOPATHIC
8 ROCHESTER
9 ROCKLAND
STATE HOSPITAL
10 ST. LAWRENCE
11 UTICA
12 WILLARD
13 CENTRAL ISLIP
14 KINGS PARK
15 PILGRIM
16 BROOKLYN
17 CREEDMOOR
18 MANHATTAN
NOTE DUE TO INTENSE OVERLAPPING OF DISTRICTS IN THE NEW YORK CITY AREA, THEY CANNOT BE EXPRESSED GRAPHICALLY THE FIVE BOROUGHS OF THE CITY ARE SERVED IN GENERAL BY HOSPITALS 9, 13, 14, 15, 16, 17 AND 18
NEW YORK STATE HEALTH PREPAREDNESS COMMISSION
FRANKLIN
CLINTON
ST LAWRENCE
ESSEX
JEFFERSON
OSWEGO
NIAGARA
ORLEANS
MONROE
ERIE
GENESEE
WYOMING
LIVINGSTON
ONTARIO
YATES
STEUBEN
ALLEGANY
CHAUTAUQUA
CATTARAUGUS
MAYNE
ONONDAGA
CAYUGA
SENECA
TOMPKINS
CORTLAND
CHENANGO
MADISON
OSWEGO
FULTON
SARATOGA
WASHINGTON
MONTGOMERY
SCHENECTADY
ALBANY
RENSSELAER
COLUMBIA
GREENE
DELAWARE
SCHOHARIE
CHEMUNG
BROOME
DUTCHESS
PUTNAM
ROCKLAND
ORANGE
SULLIVAN
ULSTER
SUFFOLK
NASSAU
NEW YORK CITY

FIGURE 9

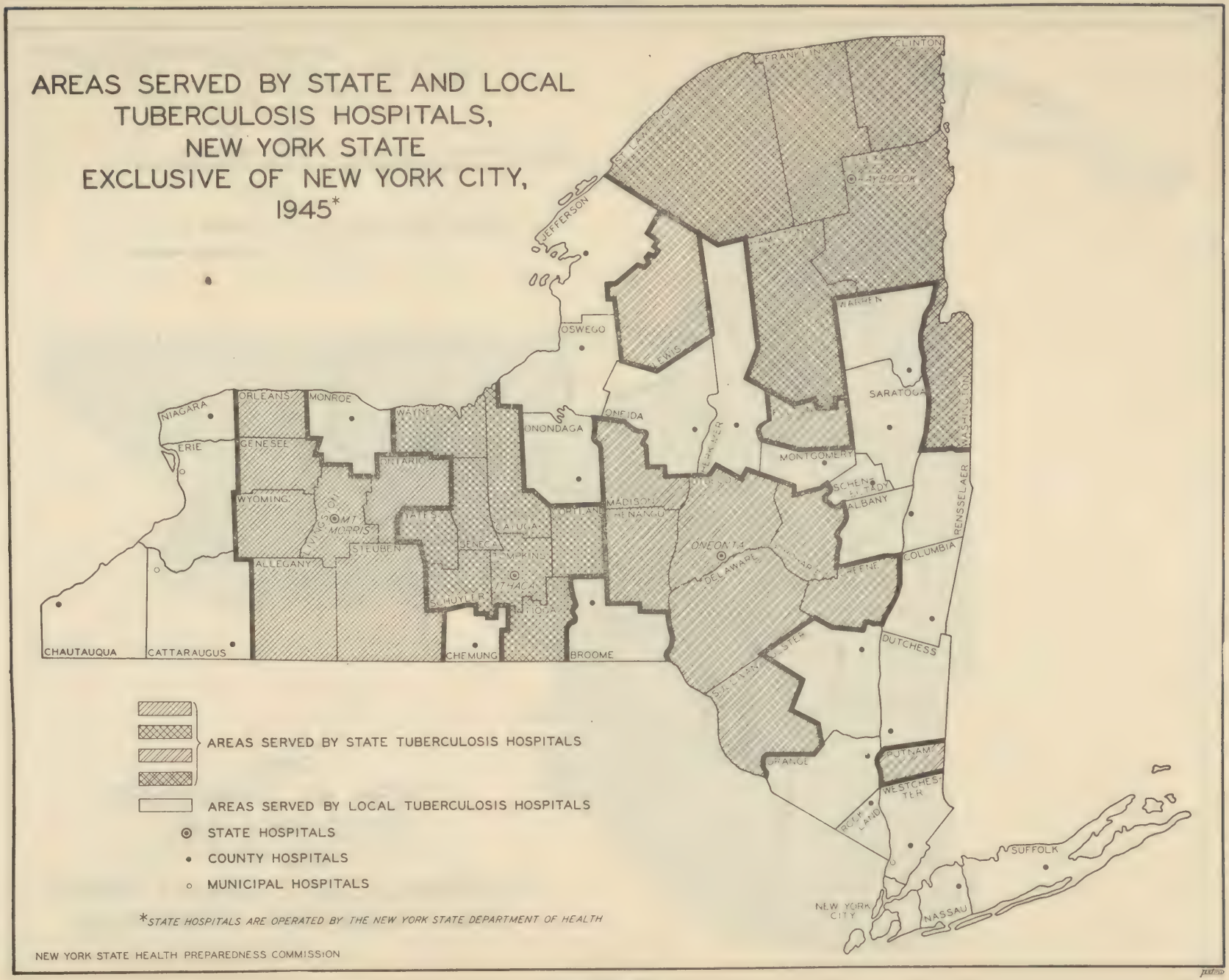

AREAS SERVED BY STATE AND LOCAL TUBERCULOSIS HOSPITALS, NEW YORK STATE EXCLUSIVE OF NEW YORK CITY, 1945*
CLINTON
FRANKLIN
ST LAWRENCE
JEFFERSON
LEWIS
OSWEGO
HERKIMER
ONEIDA
ONONDAGA
MADISON
CORTLAND
TIOGA
TOMPKINS
CAYUGA
SENECA
ONTARIO
YATES
STEUBEN
ALLEGANY
WYOMING
GENESEE
ORLEANS
MONROE
WAYNE
NIAGARA
ERIE
CHAUTAUQUA
CATTARAUGUS
CHEMUNG
BROOME
DELAWARE
SCHOHARIE
ALBANY
RENSSELAER
WASHINGTON
SARATOGA
MONTGOMERY
FULTON
COLUMBIA
DUTCHESS
ULSTER
SULLIVAN
ORANGE
PUTNAM
WESTCHESTER
ROCKLAND
SUFFOLK
NASSAU
NEW YORK CITY
AREAS SERVED BY STATE TUBERCULOSIS HOSPITALS
AREAS SERVED BY LOCAL TUBERCULOSIS HOSPITALS
STATE HOSPITALS
COUNTY HOSPITALS
MUNICIPAL HOSPITALS
*STATE HOSPITALS ARE OPERATED BY THE NEW YORK STATE DEPARTMENT OF HEALTH
NEW YORK STATE HEALTH PREPAREDNESS COMMISSION

FIGURE 10

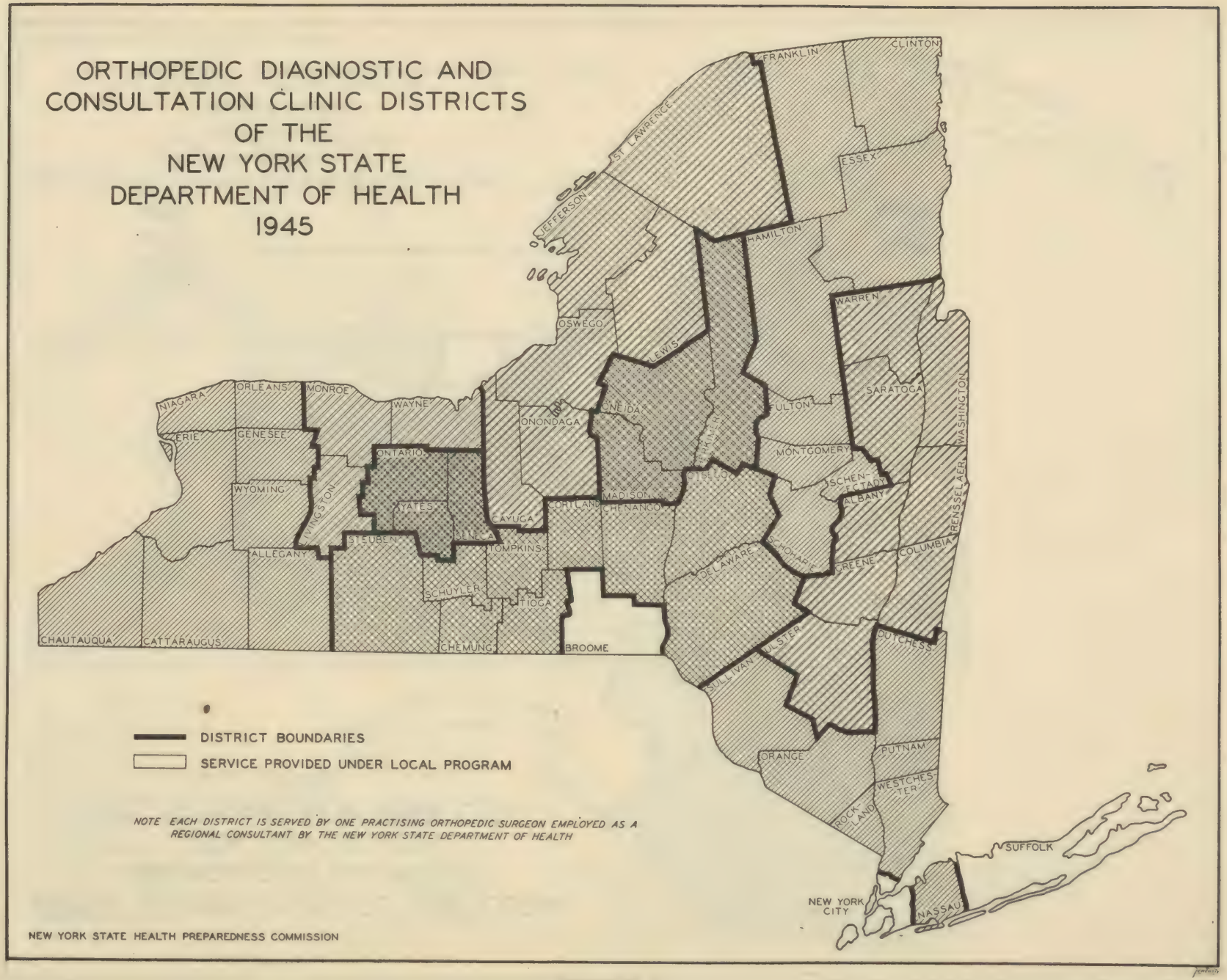

ORTHOPEDIC DIAGNOSTIC AND CONSULTATION CLINIC DISTRICTS OF THE NEW YORK STATE DEPARTMENT OF HEALTH 1945
FRANKLIN
CLINTON
ST. LAWRENCE
ESSEX
JEFFERSON
HAMILTON
WARREN
OSWEGO
LEWIS
SARATOGA
WASHINGTON
NIAGARA
ORLEANS
MONROE
WAYNE
ONONDAGA
ONEIDA
FULTON
ERIE
GENESEE
MONTGOMERY
SCHOHARIE
ONTARIO
SCHENECTADY
ALBANY
WYOMING
LIVINGSTON
YATES
MADISON
CORTLAND
CHENANGO
CAYUGA
RENSSELAER
STEUBEN
TOMPKINS
SCHOLARIE
GREENE
COLUMBIA
ALLEGANY
DELAWARE
SCHUYLER
TIOGA
DUTCHESS
CHAUTAUQUA
CATTARAUGUS
CHEMUNG
BROOME
ULSTER
SULLIVAN
ORANGE
PUTNAM
WESTCHESTER
ROCKLAND
SUFFOLK
NEW YORK CITY
NASSAU
DISTRICT BOUNDARIES
SERVICE PROVIDED UNDER LOCAL PROGRAM
NOTE EACH DISTRICT IS SERVED BY ONE PRACTISING ORTHOPEDIC SURGEON EMPLOYED AS A REGIONAL CONSULTANT BY THE NEW YORK STATE DEPARTMENT OF HEALTH
NEW YORK STATE HEALTH PREPAREDNESS COMMISSION

FIGURE 11

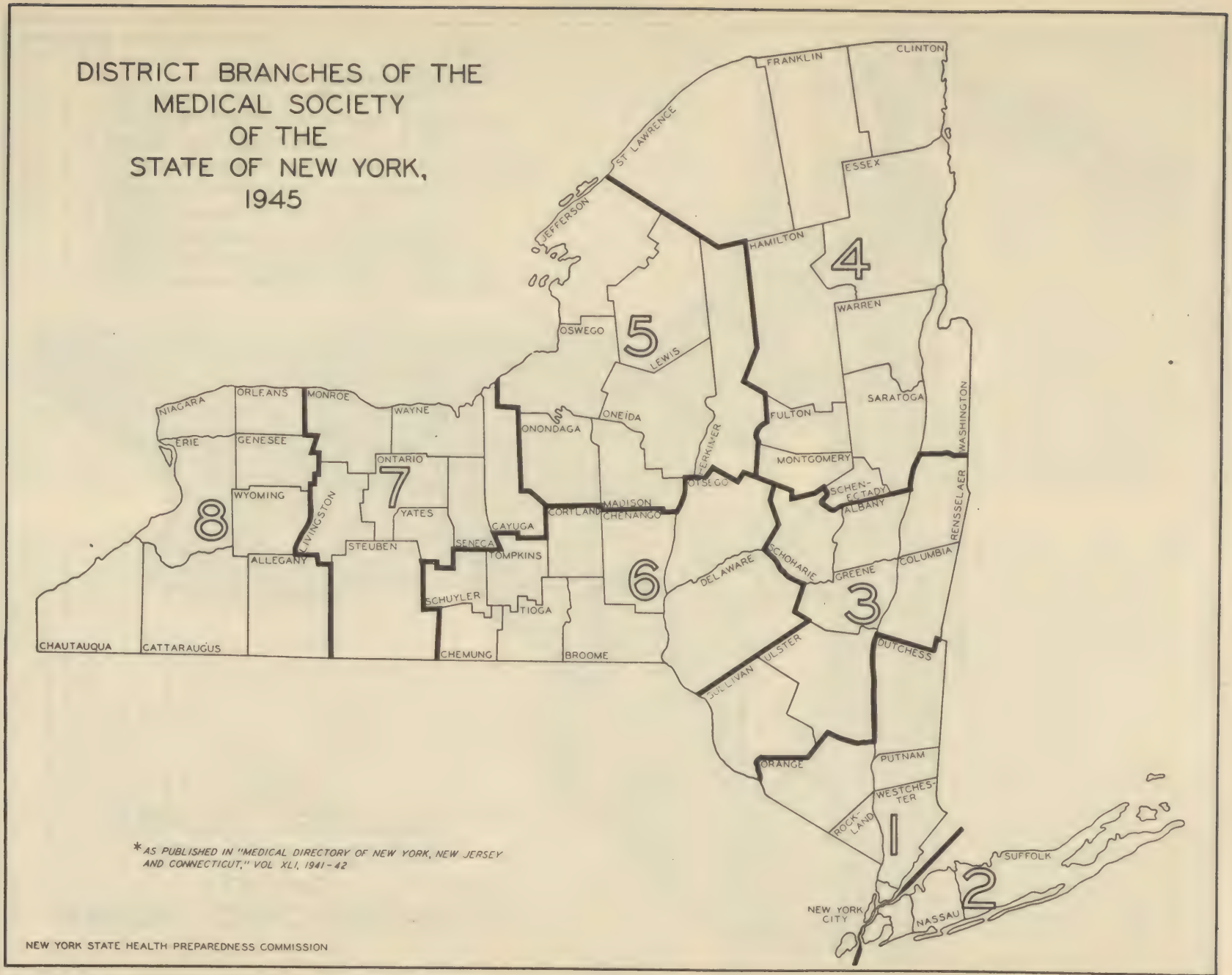

DISTRICT BRANCHES OF THE MEDICAL SOCIETY OF THE STATE OF NEW YORK, 1945
FRANKLIN
CLINTON
ST LAWRENCE
ESSEX
JEFFERSON
HAMILTON
4
WARREN
OSWEGO
5
LEWIS
SARATOGA
WASHINGTON
NIAGARA
ORLEANS
MONROE
WAYNE
ONEIDA
FULTON
ERIE
GENESEE
ONONDAGA
MOHAWK RIVER
MONTGOMERY
ONTARIO
7
SCHEN-ECTADY
RENSSELAER
WYOMING
8
LIVINGSTON
YATES
CORTLAND
MADISON
CHENANGO
OTSEGO
ALBANY
CAYUGA
SENECA
STEUBEN
TOMPKINS
ALLEGANY
6
DELAWARE
SCHOHARIE
GREENE
COLUMBIA
3
SCHUYLER
TIOGA
CHAUTAUQUA
CATTARAUGUS
CHEMUNG
BROOME
SULLIVAN
ULSTER
DUTCHESS
PUTNAM
ORANGE
WESTCHES-TER
ROCK-LAND
1
SUFFOLK
2
NEW YORK CITY
NASSAU
* AS PUBLISHED IN "MEDICAL DIRECTORY OF NEW YORK, NEW JERSEY AND CONNECTICUT," VOL XLI, 1941-42
NEW YORK STATE HEALTH PREPAREDNESS COMMISSION

FIGURE 12

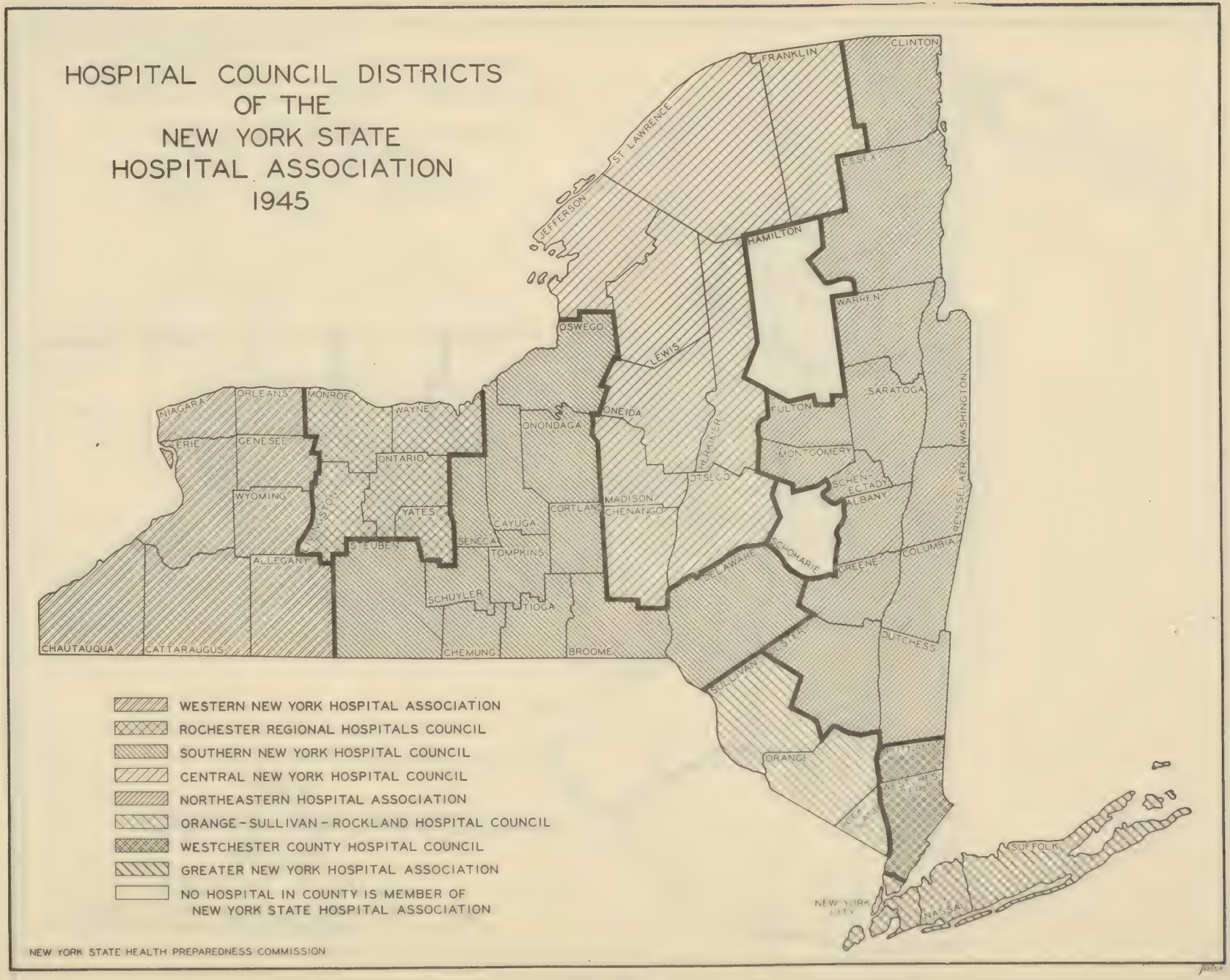

HOSPITAL COUNCIL DISTRICTS
OF THE
NEW YORK STATE
HOSPITAL ASSOCIATION
1945
FRANKLIN
CLINTON
ST LAWRENCE
ESSEX
JEFFERSON
HAMILTON
WARREN
OSWEGO
LEWIS
SARATOGA
WASHINGTON
NIAGARA
ORLEANS
MONROE
WAYNE
ONONDAGA
ONEIDA
FULTON
ERIE
GENESEE
ONTARIO
MONTGOMERY
SCHENECTADY
ALBANY
WYOMING
LIVINGSTON
YATES
OTSEGO
MADISON
CHENANGO
CORTLAND
CAYUGA
RENSSELAER
SENECA
STEUBEN
TOMPKINS
SCHOHARIE
COLUMBIA
ALLEGANY
DELAWARE
GREENE
SCHUYLER
TIOGA
DUTCHESS
CHAUTAUQUA
CATTARAUGUS
CHEMUNG
BROOME
ULSTER
SULLIVAN
ORANGE
SUFFOLK
NEW YORK CITY
NASSAU
WESTERN NEW YORK HOSPITAL ASSOCIATION
ROCHESTER REGIONAL HOSPITALS COUNCIL
SOUTHERN NEW YORK HOSPITAL COUNCIL
CENTRAL NEW YORK HOSPITAL COUNCIL
NORTHEASTERN HOSPITAL ASSOCIATION
ORANGE - SULLIVAN - ROCKLAND HOSPITAL COUNCIL
WESTCHESTER COUNTY HOSPITAL COUNCIL
GREATER NEW YORK HOSPITAL ASSOCIATION
NO HOSPITAL IN COUNTY IS MEMBER OF
NEW YORK STATE HOSPITAL ASSOCIATION
NEW YORK STATE HEALTH PREPAREDNESS COMMISSION

FIGURE 13

SOME EXAMPLES OF REGIONAL HEALTH PLANNING

As previously stated, there is nothing novel in the operation of health and medical care facilities on a regional basis. In some areas of this country and Canada the establishment of voluntary relationships between small community hospitals, regional hospitals and teaching centers has resulted in raising the quality of medical care, increasing its availability to the public and giving practitioners an opportunity to improve their professional skills. The brief summaries of the following plans may help to illustrate the potentialities in this direction. One proposal was never realized by its creator, Dr. Biggs, perhaps because of its prematurity in point of time. Two plans, the Bingham Associates Fund and that of Saskatchewan, Canada, are now in operation. Another in the Rochester area of New York State is in the process of development. All of these examples cited are of value in indicating the possibilities of the proposals set forth in this report.

THE HEALTH CENTER PLAN OF DR. BIGGS

In New York State, the principle of a health center was advocated in 1920 by Dr. Hermann S. Biggs, the then State Commissioner of Health.

At his suggestion, there was introduced into the 1920 session of the New York State Legislature the Sage-Machold Bill. During the 1918 influenza epidemic, Dr. Biggs had been impressed by, and subsequent survey had emphasized, the relative lack of health and medical services in the rural areas of the State. The purpose of the bill was "not only to develop school medical service, public health nursing and public health education throughout the State, but also to encourage and provide facilities for an annual medical examination . . . , bacteriological and chemical laboratory diagnoses, X-ray facilities . . . , expert clinical consultation service . . . , hospital and dispensary facilities and nursing." The bill proposed the establishment of local Health Centers, supported by 50 per cent State funds, which would include hospital, dispensary, consultation, laboratory and public health and nursing services.[30]

The health center as described in the bill is not necessarily a single physical unit, but could embrace physically separated hospitals, clinics, laboratories and public health centers. Services would, for the most part, be rendered by full or part-time salaried physicians. Private physicians, however, could continue to treat patients after admission to the hospital or health center, if the patient so desired.

A means test would be applied to all patients and charges made in accordance with ability to pay. The public welfare district would be liable for costs which the patients could not meet. Funds for establishing and operating the center would come from fees, local taxes and State aid.

Existing hospital and clinic facilities would not be given financial aid except maternal and child welfare, tuberculosis and venereal disease facilities.

Establishment of health centers would depend on the decision of county or city legislative bodies. Each center would be under the general supervision of a board of managers, of whom two must be physicians and which would appoint a superintendent who must meet the qualifications provided by the State Public Health Council. All the activities of the centers would be subject to general supervision of the State Department of Health.

The bill as introduced failed of passage in 1920 and again when reintroduced in 1921. It was not reintroduced in 1922. In 1923, however, there were enacted chapters 662 and 638 of the Acts of 1923, the first of which provides for 50 per cent State aid for "county, community or other public hospital, clinic, dispensary or similar institution or any public health work" undertaken by counties, and the second of which provides for similar aid for county laboratories. (Sections 19 and 20-h of the present Public Health Law.)[31]

THE BINGHAM ASSOCIATES FUND

In 1931, as a result of the philanthropy of Mr. William Bingham, 2nd, of Bethel, Maine, stimulated by the interest of his friend Dr. George B. Farnsworth, there was organized, under Maine laws, the Bingham Associates Fund. Its stated purpose was the advancement of medicine in Maine, with particular reference to improvement of diagnostic facilities and consultation service in the rural areas of the State.

> "The plan of the Bingham Associates Fund is . . . to extend into small communities the medical advantages of a metropolitan center by direct and indirect contacts between these elements . . . on a permanent working basis. It is intended that small communities . . . maintain opportunities for independent work, but that it shall be integrated with that of larger centers."[32]

The first action of the Fund was to equip fully a small local hospital in Oxford County, Maine, and to arrange for regular clinics there, presided over by Dr. Joseph H. Pratt, Clinical Professor of Medicine at Tufts College Medical School and his assistants.

In 1932 a 20-bed diagnostic clinic, for problem cases, was established in Boston at the Boston Dispensary. In December 1938, there was opened the Joseph H. Pratt Diagnostic Hospital of 65 beds. A

[30] In view of both the historical interest and present timeliness of this proposed legislation a copy of this bill is reprinted in full in Appendix A, p. 73 et seq.

[31] Sections 19, 19-a, 19-b and 20-b of the Public Health Law were amended in 1946. Since they are pertinent as indicating advancements along the lines proposed by Dr. Biggs, a copy of the legislation containing these amendments is set forth in Appendix A, p. 77.

[32] The Bingham Associates Fund (Boston: Thomas Todd & Co., 1945), p. 7.

regionalization plan, providing for exchange and integration of services between the Boston "base," two regional hospitals in Bangor and Lewiston and 24 community hospitals in Maine, was begun in July 1937.

The base or metropolitan center in Boston consists of a "teaching base" and a "clinical base." The teaching base is Tufts College Medical School and furnishes undergraduate and postgraduate instruction to physicians from the rural areas served. The clinical base is primarily the Joseph H. Pratt Diagnostic Center and furnishes diagnostic service for obscure medical problems arising in patients from these rural areas.

There are two *regional centers,* the Central Maine General Hospital in Lewiston, and the Eastern Maine General Hospital, Bangor, Maine. Each center serves the hospitals of thirteen communities.

The integration and sharing of services operates along three main lines: (1) clinical diagnostic aid, (2) hospital extension services, (3) postgraduate medical education.

Hospital Diagnostic Service. The Joseph H. Pratt Diagnostic Hospital receives patients only upon referral by a private physician, who makes the decision whether the community hospital, the regional hospital or the base hospital best can handle the case. Reports upon the results of the diagnostic work again are made to the referring physician. The physician-patient relationship is thus protected and maintained.

Pathology. The community hospitals usually have no pathologists. They send specimens for diagnosis to the regional center, which in turn sends questionable or problem specimens to the base hospital center. The regional center pathologist will, on request, perform autopsies at the community hospitals and is available for clinico-pathological conferences at these hospitals.

Electrocardiography. A representative of a community hospital is given a week's free instruction in reading electrocardiographs, provided the hospital will purchase an electrocardiograph. Copies of tracings are sent to the regional center whose reports are available as a check on the local report. Difficult tracings are sent to the base.

Roentgenology. Regional seminars attended by community hospital radiologists are held every two weeks at one of the regional hospitals. These seminars discuss films taken during the preceding two weeks; all routine films are sent in advance to the regional center. Emergency films requiring help between seminars are read also by the regional radiologist. The regional radiologists, in turn, attend weekly radiological seminars in Boston at the Massachusetts General Hospital. The X-ray technicians of the community hospitals meet every second month for a conference on their own problems. Fellowships for further study are available to them.

Laboratory. Laboratory technicians of the community hospitals spend one month annually in Boston for the purpose of improving their technique and learning new procedures. The Fund provides traveling technicians to substitute in the hospitals during the regular technicians' absence.

For hospitals too small to employ full-time technicians, the Fund provides a three-months' course at Boston for instruction of a graduate nurse designated by the hospital. Annual one-month courses are available to these nurses also. Difficult laboratory tests are performed in the regional center laboratories which may also provide solutions of standard reagents for use in laboratory tests.

Dietetics. Dietitians of the community hospitals are given an annual one-month refresher course in dietetics at the New England Medical Center.

Library Assistance. At one of the regional centers, the library provides for the community hospitals such service as preparing bibliographies, mailing out books and a regular mailing service on current journals.

Postgraduate Teaching in the Community Hospital by Ward Rounds. Once a month, instructors from the teaching center conduct teaching ward rounds in the community hospitals. In this way most of the physicians in the community hospitals are reached by a large number of the staff of the teaching center.

"Refresher" Courses for General Practitioners. Short courses of one to four weeks duration, designed especially for general practitioners, are given each year at the New England Medical Center (Boston). For a one month's course, the physician receives a stipend of $250 and there is no tuition fee. For shorter courses, no tuition fee is charged to Maine physicians; to other physicians, a nominal charge is made. Since it was found that only 10 per cent of physicians are interested in courses as long as one month, the one-week courses were instituted to reach a larger proportion of practitioners.

Other Postgraduate Educational Activities. The Diagnostic Hospital Service is itself a medium of postgraduate education through the detailed reports on referred patients which are made to the local physician referring the case. These reports are often accompanied by pertinent references or quotations from the literature. Follow-up information regarding patients is also sent out by the base center hospital. In addition, a *Bulletin,* published every two months, containing clinical notes and articles is sent by the teaching hospital to physicians in the rural areas.

HEALTH SERVICES PLANNING IN SASKATCHEWAN, CANADA

In Saskatchewan, a widely scattered rural population, difficult transportation problems and generally insecure economic conditions have kept both the quantity and quality of medical services, preventive as well as therapeutic, at a low level. In response to the need there has grown up a municipal-doctor system, in which the physician is paid out of tax funds. A number of municipalities, or parts of municipalities, have united to form hospital districts providing small hospital centers whose cost is also borne by local communities. These centers are usually not adequately equipped and only 25–30 per cent of the population are included in the municipal-doctor and hospitalization plans.

Since November 1944, a Health Services Planning Commission has been at work on plans to provide adequate preventive treatment, hospital and consultation services for all the province. The Commission has consulted with a widely representative advisory committee and with local community representatives. The Commission proposes to extend the municipal-doctor system, encouraging the formation of group practices. Financial assistance will be offered for medical care, for construction of new hospitals and health centers, and for adding to existing ones. As much as possible, control of local hospitals will remain in the hands of the localities.

To provide for services which require a larger population and financial base than can be furnished by a municipality or a hospital district, a regional plan has been drawn up. Fourteen regions are proposed, having each a population of 40,000 or more.

In each region there will be a *Main Regional Hospital,* having facilities for major surgery, laboratory, diagnostic and consultation work. The regional hospital will care for patients who cannot be looked after in the small rural hospitals or local health centers. Two *Main Centers* (at Regina and Saskatoon) will care for patients requiring any specialized diagnostic or treatment procedures, such as brain and chest surgery.

In most regions there would also be one or two smaller *district hospitals.* Their staffs would be assisted by the staff of the regional hospital, which would do such work as X-ray and electrocardiographic diagnosis for them.

The smallest unit would be the 8–15 bed local health centers, for maternity work, emergency work and routine work not requiring full hospital facilities. Physicians working in these centers would have at their disposal the facilities of the district and regional hospitals.

Financial assistance offered by the Provincial Government would include (1) a small per capita grant for localities adopting an approved plan, (2) a sliding scale of equalization grants for the poorer communities based on financial need. Financial assistance for new construction and added construction of hospitals and health centers is also offered.

The entire plan is elastic and may be altered in accordance with local and regional needs and conditions.

THE COUNCIL OF ROCHESTER REGIONAL HOSPITALS, INC.

In its report on the County Studies[83] the Commission indicated that the extent to which the technique of voluntary cooperation as applied at the county level in the studies could be successful on a regional plane in New York State remained an open question. The query was posed whether regional planning, taking into consideration all public health and medical care services in an area, could be made effective on a voluntary basis or would an official governmental agency be required to guide and direct it.

The present experiment now being carried on in Rochester, New York, may help to indicate an answer to this problem.

Made possible by a grant from the Commonwealth Fund, an experiment in regional hospital organization was inaugurated in March of 1946 in a seven-county area surrounding Rochester, New York. The legal entity carrying on the work is the Council of Rochester Regional Hospitals, Inc. In this region which has a population of 714,000 and which covers 4,715 square miles, are 18 voluntary hospitals, six of which are located in the City of Rochester, which also includes the University of Rochester School of Medicine and Dentistry. Also in the region, there are seven proprietary hospitals as well as several governmental hospitals of varying natures.

As a result of the Fund's experience in its Division of Rural Hospitals, it became evident that small community hospitals should have competent administrative advice available at all times, and that a better distribution of the services of physicians, nurses, and other medical personnel, now concentrated in the cities, should be brought about. It appeared also that greater opportunities in postgraduate education for physicians practicing in rural communities should be created, that more attention should be given to rural needs in undergraduate education of physicians and other medical personnel, and that consultant service should be more freely available in many lines.

In pursuit of the belief that these objectives might be attained, the Rochester region was selected for an experiment in bringing together in close affiliation the hospitals located in the area and in Rochester. It is hoped that a cooperative effort of the hospitals will develop a pattern of efficient medical service of higher order than is the case where independent action exists.

The essence of the plan is to determine whether "concerted voluntary action by the hospitals through representative organization on a regional scale" will

[83] Leg. Doc. (1944) No. 56A, *op. cit.*

help significantly in bringing about further progress in rural medicine. The premises for such a plan are two-fold; that isolated hospitals in small towns need long-continued aid and counsel from outside sources if they are to rise to the full measure of their opportunities, and, second, that the natural sources from which such aid and counsel should come are the urban hospitals. The proposed region is designed to link a geographically coherent group of small hospitals with the large hospitals in an accessible center.

The existing resources in the area hospitals must be thoroughly studied. Other health facilities in the seven counties will be carefully surveyed in order to discover how best these facilities can be supplemented by aid from the regional organization.

The linking of the area hospitals with those in the city will permit an interchange of services involving interne rotation in acceptable area hospitals, fellowships in urban hospitals granted area physicians and nurses, an advisory service in the special fields of medicine, and teaching institutes available to area physicians both in the city and area hospitals.

The educational facilities will be developed by the several conferences appointed for this purpose. The grant from the Commonwealth Fund provides the means for supplementing existing educational facilities. As the experiment progresses the grant also provides for financial aid to area hospitals in need of capital improvements.

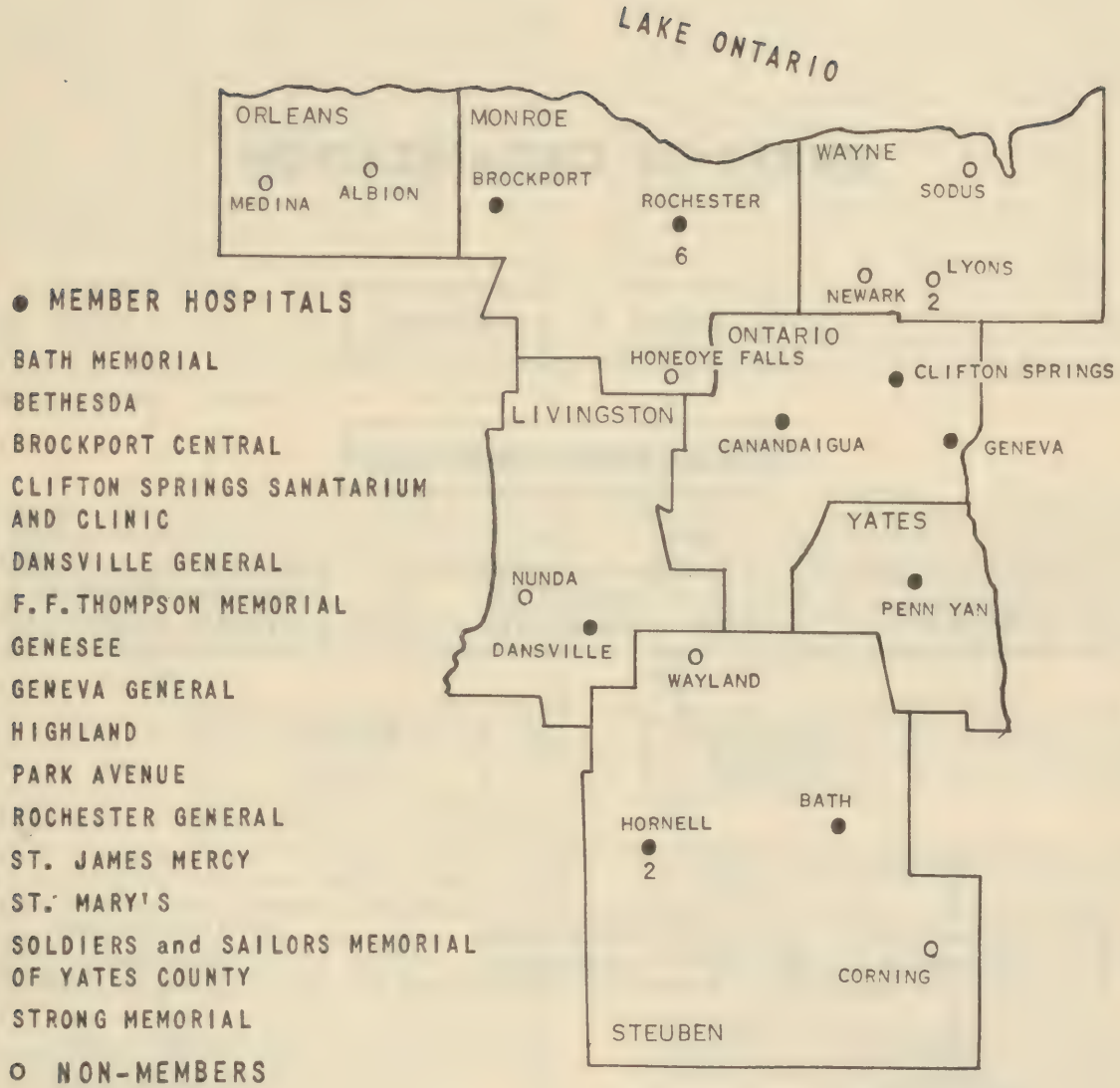
The experience gained in this regional health experiment is intended to serve as a pattern for other areas in the country. It is entirely a voluntary effort of the regional hospitals to build a more coherent medical and nursing program dependent upon the individual participation of the physicians in the area.

To carry out such an experiment, the hospitals organized along democratic lines. The governing board of the Council of Rochester Regional Hospitals is composed of lay board members, affording equal representation for all voluntary hospitals and representatives of the general public, one from each county. To develop the program at the working level, there have been set up two groups, a Medical Conference composed of physicians, and an Administrators' Conference composed of administrators representing their hospitals. The nature of the activities for which the Conference is responsible is such as the name implies. Specific standing committees within the Conferences such as Purchasing; Nursing; Accounting; In-Service Training; and Records, Reports and Statistics in the Administrators' Conference and in the Medical Conference: Interns and Residents; Medical Procedures; Medical Staff Organization and Activities; and Teaching Institutes. These Conferences function independently of each other except as they are interrelated by a liaison committee made up of the officers of each Conference.

As the program develops, associate membership will be offered proprietary and governmental hospitals on the premise that all should participate if the experiment is to determine whether concerted voluntary action by the hospitals through representative organization on a regional scale will help significantly in bringing about further progress in rural medicine.

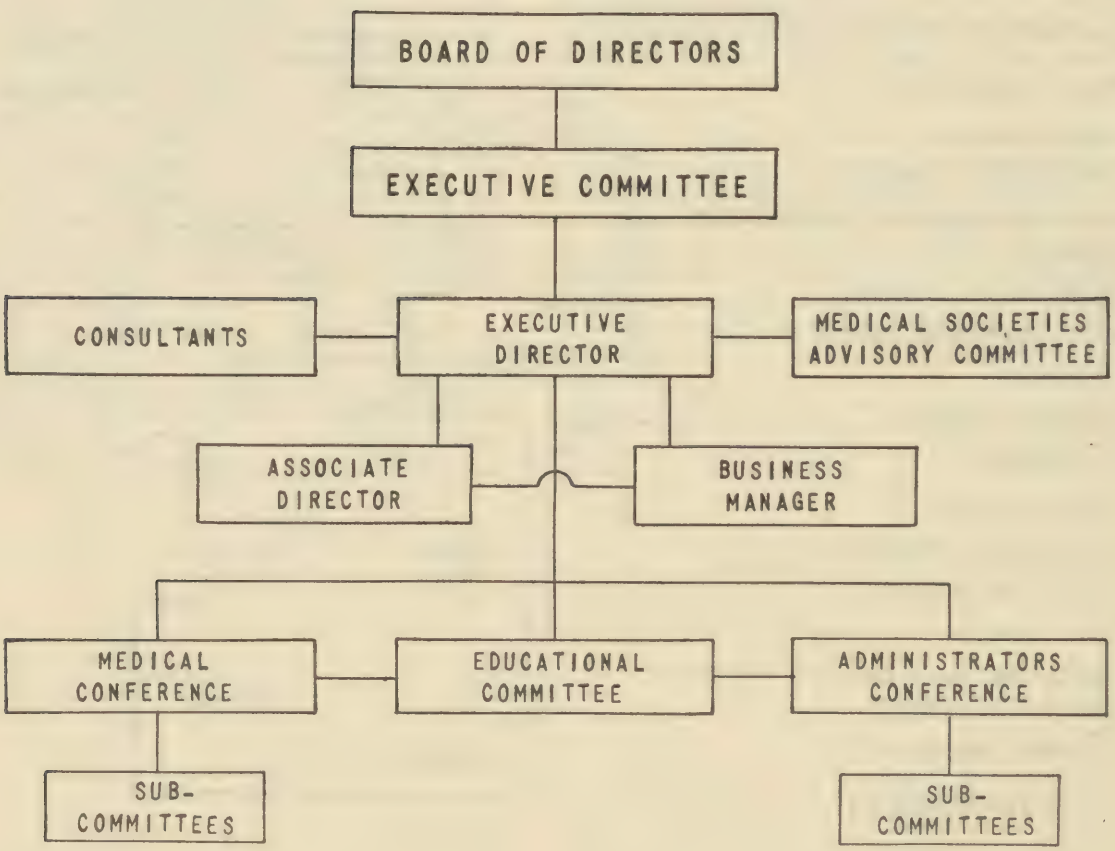
A copy of the map of the region and the chart of organization are reproduced herewith.[34]

[34] The foregoing material was secured from the Regional Bulletin, Vol. 1, No. 1, Council of Rochester Regional Hospitals, Inc., May 1, 1946, and a written communication from the Council.



TOTAL AREA	4715 SQ. MILES
TOTAL POPULATION	713,862

CHART OF ORGANIZATION



THE NEXT STEPS

The Commission is cognizant of the many varied factors that must be considered in formulating a plan for the care of the chronically ill. The proposed health service areas mark merely a beginning in this direction. It is of course imperative to ascertain precisely how the chronically ill are now cared for within these boundaries. The attitudes of hospital administrators as to the needs of the chronically ill and the suggestions of local commissioners of public welfare on planning for their care are being carefully weighed. The existing nursing homes in the State, their methods of operation, condition of their physical plants, statistical data concerning them and their licensure in various localities are some of the elements that have been and are the subject of serious inquiry. Official planning for care of the chronically ill in other states as well as their procedures in licensing nursing homes are being thoroughly considered. Sufficient information concerning the incidence of chronic illness in the State will be assembled to enable workable formulae to be developed for general planning. Résumés of the major aspects of the most prevalent chronic disease entities, written by specialists in their fields, will help the lay public to appreciate the medical aspects of this problem.

It is the intention of the Commission to submit any contemplated plan to careful scrutiny by the interested official and voluntary State and local agencies as well as individual experts so as to profit by their criticisms and suggestions. The financial aspects, including the estimated cost of capital construction and of the operation of facilities, must be explored. The various steps required to put a plan in operation after its adoption must be determined. The fixing of administrative responsibility on the local and State level in implementing the plan requires careful consideration. Finally, the necessary legislation must be drawn that will enable a plan to be put into action.

Workable procedures developed to care for the chronically ill will be of inestimable value in furthering any future projects dealing with overall regional planning.

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PART II
APPENDIX A

LETTER SENT BY HON. LEE B. MAILLER, STATE CHIEF OF EMERGENCY MEDICAL SERVICE TO LOCAL CHIEFS OF EMERGENCY MEDICAL SERVICE AFTER ISSUANCE OF MEMORANDUM NO. 97 PLACING THEM ON A RESERVE BASIS.

May 15, 1945

DEAR DOCTOR:

Pursuant to Memorandum No. 97 of the State Director of Civilian Protection, the members of the New York State Civilian Protection Force have been placed on a reserve basis. The extent to which the Emergency Medical Service will continue actively in your area depends on the local plans and wishes of your community. Up to the present, no definite instructions for the disposition of equipment loaned by the Federal Office of Civilian Defense have been issued. When they are, you will be advised.

On behalf of the Health Preparedness Commission and myself, we wish to express to you, as Local Chief, the other physicians serving with you, the nurses and lay members of the Emergency Medical Service, our deep gratitude and appreciation for the manner in which all the personnel so nobly responded and cooperated in time of necessity. Although we were very fortunate to escape enemy attack, the value and utility of Emergency Medical Service organization and training were graphically illustrated by the excellent work it performed in various civilian disasters in the State. This was possible only because of unselfish personal sacrifices in time and energy, regular drills, often during night blackouts and even under bad weather conditions as well as long hours of voluntary effort freely given. Functioning through Emergency Medical Service, your community thus prepared itself to aid its citizens in any contingency.

All of this was done despite increasing work placed upon doctors and nurses due to the fact that many medical and nursing personnel had joined the Armed Forces.

The Emergency Medical Service fills a glowing page in the history of community cooperation on the home front in wartime. We are happy and proud to have served with you.

Sincerely yours,

LEE B. MAILLER,
State Chief of Emergency Medical Service

LETTER SENT BY HON. LEE B. MAILLER, STATE CHIEF OF EMERGENCY MEDICAL SERVICE TO LOCAL CHIEF OF EMERGENCY MEDICAL SERVICE INDICATING A PROCEDURE FOR CONTINUING LOCAL EMERGENCY MEDICAL SERVICES ON A PEACETIME BASIS.

September 12, 1945

DEAR DOCTOR:

By this time you have undoubtedly received Memorandum No. 103 of the Acting State Director of Civilian Protection advising you that the Civilian Protection Forces placed on reserve after V-E Day may now be demobilized.

Since our last communication to you, many physicians have discussed with me possible methods by which the concept of the Emergency Medical Service might be perpetuated locally in peacetime. They feel that it has proven itself to be an invaluable community asset that should not be allowed to disintegrate and that efforts should be made to convert it into a permanent community resource.

One of the suggested procedures is a consolidation of the Emergency Medical Service with the Red Cross Disaster Service.

Shortly after the war began, an agreement was reached between the American National Red Cross and the Office of Civilian Defense, which recognized the responsibility of the Red Cross for relief operations related to non-enemy caused disasters affecting the civilian population. In such emergencies, the Emergency Medical Service of the Citizens' Defense Corps was to be at the disposal of the local American Red Cross Chapter Disaster Committee. Where caused by enemy action, the responsibility for the care of civilian casualties was charged to the Emergency Medical Service of the Citizens' Defense Corps, and the American Red Cross Disaster Committee was also to function under the Commander of the Citizens' Defense Corps.

With the cessation of hostilities, the possibility of enemy caused disaster has passed. However, the Red Cross is continuing its regular program of being prepared to serve the public in the event of any unforeseen catastrophe. To enlarge and strengthen the Disaster Relief Services of local chapters so that they may operate more effectively as a community facility in the event of necessity, the American Red Cross has recently added more physicians and other staff personnel to its National and Area offices.

The American Red Cross is advising all its chapter chairmen to communicate with local Chiefs of Emergency Medical Service and Commanders of Civilian Defense Corps to discuss ways and means whereby the local EMS might be integrated with the Red Cross Disaster Service. Should an emergency arise in your community or elsewhere, such cooperation would enable a maximum of performance to be achieved. Moreover, a means would be provided whereby the machinery created through war conditions could be preserved and utilized on a permanent peacetime basis.

We sincerely urge you to give careful consideration to any proposals you may receive along these lines from your local Red Cross Chapter.

Thanking you once more for your cooperation, I remain,

Sincerely yours,

LEE B. MAILLER,
State Chief of Emergency Medical Service

STATE OF NEW YORK

No. 2529 Int. 2274

IN ASSEMBLY

March 4, 1946

Introduced by Mr. MAILLER—read once and referred to the Committee on Ways and Means

AN ACT

To amend the public health law and the county law, in relation to providing more adequately for the care and treatment of persons suffering from tuberculosis, providing for the establishment of standards and regulations governing the facilities, operation, administration and future conduct of tuberculosis hospitals and general hospitals having special facilities for such care and treatment, authorizing and providing for state aid to counties and cities for expenditures therefor, and making other provisions incidental thereto and in connection therewith

The People of the State of New York represented in Senate and Assembly do enact as follows:

Section 1. Section four of chapter forty-nine of the laws of nineteen hundred nine, entitled "An act in relation to the public health, constituting chapter forty-five of the consolidated laws," as last amended by chapter three hundred thirty-five of the laws of nineteen hundred thirty-six, is hereby amended to read as follows:

§ 4. General powers and duties of commissioner. The commissioner of health shall take cognizance of the interests of health and life of the people of the state, and of all matters pertaining thereto. He shall exercise general supervision over the work of all local health authorities except in the city of New York. [He shall have general supervision and control of the medical treatment of patients in the New York state hospital for the treatment of incipient pulmonary tuberculosis at Raybrook and the New York state orthopedic hospital for children at West Haverstraw.] He shall be charged with the enforcement of the public health law and the sanitary code. He shall make inquiries in respect to the causes of disease, especially epidemics, and investigate the sources of mortality, and the effect of localities employments and other conditions, upon the public health. He shall obtain, collect and preserve such information relating to mortality, disease and health as may be useful in the discharge of his duties or may contribute to the promotion of health or the security of life in the state. He may issue subpoenas, compel the attendance of witnesses and compel them to testify in any matter or proceeding before him, and a witness may be required to attend and give testimony in a county where he resides or has a place of business without the payment of any fees. The commissioner of health may reverse or modify an order, regulation, by-law or ordinance of a local board of health concerning a matter which in his judgment affects the public health beyond the territory over which such local board has jurisdiction. He may in his discretion from time to time create health districts comprised exclusively of lands lying within the boundaries of a state park by filing in the office of the secretary of state an order defining generally the boundaries of such district or districts. Upon the making and filing of such an order the local board of health of such district shall consist of the park commission and ex-officio the state commissioner of health or his duly authorized representative. Such board of health shall have all the powers and duties of local boards of health and shall appoint a health officer qualified as provided by regulation of the public health council. Such health officer shall have all the powers and duties under the law of the state and the state sanitary code which local health officers now have or hereafter shall have within their respective localities. The state health commissioner may from time to time modify or repeal such order or orders. The commissioner of health and any person authorized by him so to do, may, without fee or hindrance, enter, examine and survey all grounds, erections, vehicles, structures, apartments, buildings and places. Wherever, in this chapter, the commissioner of health is empowered to or charged with the responsibility to do or perform any act, he may deputize in writing any assistant commissioner, administrative officer, or any director of a division in the department to do or perform the act in his place and stead.

§ 2. Such chapter is hereby amended by inserting therein a new article, to be article four, to read as follows:

ARTICLE 4

GENERAL PROVISIONS GOVERNING CARE AND TREATMENT OF PERSONS SUFFERING FROM TUBERCULOSIS AND STATE AID TO COUNTIES AND CITIES FOR CERTAIN EXPENDITURES THEREFOR

EXPLANATION—Matter in *italics* is new; matter in brackets [ ] is old law to be omitted.

§ 50. Availability of facilities for diagnosis, care and treatment without cost. Notwithstanding any inconsistent provision of this chapter or of any other general, special or local law or city charter, care and treatment provided by a state, county or city for persons suffering from tuberculosis, and diagnoses, tests, studies and analyses for the discovery of tuberculosis, shall be available without cost or charge to any resident of the state who is suffering from tuberculosis or is suspected of having tuberculosis. Any such person who volunteers to assume and pay for the cost of such care and treatment or for the cost of such diagnosis, test, study or analysis shall be permitted to do so; but no state, county, city or other public official shall request or require such payment or make, or cause to be made, any inquiry or investigation for the purpose of determining the ability of such person or of his legally responsible relatives to pay therefor.

§ 51. State aid to counties and cities for the care and treatment of tuberculosis patients. 1. Whenever any county or city shall expend moneys for the operation and maintenance of a hospital operated exclusively for the care and treatment of tuberculosis patients, or whenever any county or city shall expend moneys for the operation of a general hospital which includes a special wing or pavilion for the treatment of tuberculosis patients, such county or city shall receive state aid in the manner and subject to the terms and conditions prescribed by this article and the rules and regulations promulgated by the state commissioner of health thereunder.

2. Subject to the terms and conditions prescribed by this article and the rules and regulations promulgated by the state commissioner of health thereunder, the city of New York and any county outside of such city not included in a state tuberculosis hospital district, in which county there in no public tuberculosis hospital, shall be entitled to state aid for the care and treatment of tuberculosis patients in a non-profit hospital operated by a corporation or a private agency provided that: (a) such care and treatment is given pursuant to an annual contract between such city or county and such hospital; (b) such hospital is a tuberculosis hospital which has at least one hundred beds but not more than five hundred beds for tuberculosis patients or patients suffering from pulmonary diseases, or is a general hospital which has a special tuberculosis department with a capacity of at least one hundred beds but not more than five hundred beds which are used exclusively for the care and treatment of patients suffering from tuberculosis or pulmonary diseases; (c) such hospital shall conform with standards established by the state commissioner of health.

3. Notwithstanding the provisions of subdivision two of this section but subject to the terms and conditions otherwise prescribed by this article and the rules and regulations of the state commissioner of health authorized thereunder, any county providing for the care and treatment of tuberculosis patients or patients suffering from pulmonary diseases under a program in effect on January first, nineteen hundred forty-six and hereafter approved by the state commissioner of health shall likewise be entitled to state aid for care and treatment pursuant to such program.

4. The governor shall appoint a committee of five physicians, of whom at least three shall be recognized specialists in diseases of the chest, to review, at the request of the state commissioner of health, all of the factors related to the facilities for, and the operation or administration of, care and treatment for patients suffering from tuberculosis or pulmonary diseases. After reviewing all of such factors related to such care and treatment for which an application for state aid has been made, the committee shall make such recommendations as it may deem appropriate regarding the granting or refusal of state aid. The members of such committee shall be appointed for terms of five years, except that the first appointees shall be appointed for terms of one, two, three, four and five years, respectively. The committee shall hold such meetings and at such places as may be designated by the state commissioner of health. Each member of the committee shall receive an annual salary of fifteen hundred dollars in addition to any traveling or other expenses actually and necessarily incurred in attending such meetings or in visiting hospitals or in performing any other duty in connection with the administration of this article. The committee shall from time to time make recommendations to the state commissioner of health regarding changes for the purpose of improving care and treatment of tuberculosis or the public health service dealing with tuberculosis.

§ 52. Responsibility of state commissioner of health. 1. It shall be the duty of the state commissioner of health to formulate such standards as he may deem necessary in order to carry out the objectives and provisions of this article.

2. The state commissioner of health shall make a detailed study of the administration of existing public hospitals caring for tuberculosis patients throughout the state, including New York city. He shall make, adopt, promulgate and enforce such rules and regulations as he may deem appropriate for the facilities, operation, administration and the future conduct of such hospitals under the provisions of this article, and he may, from time to time, amend or repeal the same. He shall, on or before January first, nineteen hundred forty-seven, forward to the board of supervisors of each county and to the mayor of each city, eligible for state aid under this article a copy of such rules and regulations.

3. He may recommend to counties and cities such changes in the facilities, operation or administration of such hospitals as, in his judgment, are necessary for the county or city to qualify for state aid under the provisions of this article and the rules and regulations promulgated thereunder.

4. He shall have full power and authority to examine any or all records, reports and other data pertaining to patients or the facilities, operation or administration of a hospital providing care or treatment for which a county or city applies for state aid, to examine or cause to be examined any patient in such hospital and to make or cause to be made such laboratory tests or X-ray examinations as in his judgment may be desirable.

§ 53. Limitations and conditions regarding county and city hospitals. No state aid shall be payable under the provisions of this article to any county or city for any county or city hospital:

(a) which hereafter is constructed or enlarged to a capacity in excess of five hundred beds for tuberculosis patients;

(b) which, in the opinion of the state commissioner of health, is not providing a safe and scientific program of patient care and treatment;

(c) which has an appropriate bed available and refuses to accept for treatment a patient who may be recommended for admission to such hospital by the state commissioner of health.

(d) In which a tuberculosis patient is requested or required to pay for his care or treatment.

(e) Which fails to comply with the provisions of this article or the rules and regulations of the state commissioner of health promulgated thereunder.

§ 54. Amount of state aid. 1. Whenever the board of supervisors of any county or the common council or other body exercising similar powers of any city shall appropriate and expend moneys for the operation and maintenance of a hospital wholly for the care and treatment of tuberculosis patients, as provided in this article, such county or city shall receive state reimbursement in the amount of fifty per centum of the per diem patient cost of care and treatment, but not more than two dollars and fifty cents per patient day, as approved by the state commissioner of health in accordance with the provisions of this article, exclusive of the cost of reconstruction or of the construction of additional facilities.

2. Whenever the board of supervisors of any county or the common council or other body exercising similar powers of any city shall appropriate and expend moneys for the care and treatment of tuberculosis patients in a special wing or pavilion of a general hospital as provided in this article, such county or city shall receive state reimbursement in the amount of fifty per centum of the per diem patient cost of care and treatment, but not more than two dollars and fifty cents per patient day,

for each patient actually cared for and treated in such wing or pavilion of such general hospital.

3. The actual cost of care and treatment of tuberculosis patients in such hospitals shall be the per diem cost of operation and maintenance of such hospital, to be computed annually by the state commissioner of health from annual statements showing the total cost of the operation and maintenance of such hospital, exclusive of the cost of reconstruction or of the construction of additional facilities. The per diem cost rate thus computed shall be in force for the next twelve months period immediately following the close of the twelve months period covered by the statement from which such per diem cost was computed.

4. Whenever any county or city shall appropriate and expend moneys for the care and treatment of tuberculosis patients in a hospital owned and operated by some other county or city, which is currently receiving state aid under the provisions of this article, the county or city operating such hospital shall be paid state aid for the care of such non-resident patients in the same manner and subject to the same conditions as state aid for the care of resident patients. The county or city operating such hospital shall charge back to the county or city of residence of such patients an amount equivalent to fifty per centum of the per diem patient cost, but not to exceed two dollars and fifty cents per day, for each day of such patients' care. The provisions of this subdivision shall not, however, apply to any county constituting a part of an area designated to be served by any state tuberculosis hospital, in accordance with section three hundred thirty-nine of this chapter.

5. Whenever the city of New York or any county outside of such city not included in a state tuberculosis hospital district, in which county there is no tuberculosis hospital, shall contract with a non-profit hospital operated by a corporation or a private agency and shall appropriate and expend moneys for the care and treatment of tuberculosis patients pursuant to such contract as provided in this article, such county or city shall receive state reimbursement in the amount of fifty per centum of the contract cost for patient care and treatment but not more than two dollars and fifty cents per patient day, as approved by the state commissioner of health in accordance with the provisions of this article.

6. Whenever any county shall appropriate and expend moneys for the care and treatment of tuberculosis patients under a program in effect on January first, nineteen hundred forty-six and hereafter approved by the state commissioner of health, such county shall receive state reimbursement in the amount of fifty per centum of the per diem cost of such care and treatment, but not more than two dollars and fifty cents per patient day, for each patient actually cared for and treated under such program.

The per diem cost of care and treatment under such program shall be computed annually by the state commissioner of health from statements showing the total expenditures made by any such county for such care and treatment during the last preceding fiscal year of such county, together with a statement showing the total number of patient days of such care and treatment represented by such statement of expenditures.

§ 55. Appropriations to be available for cost of administration. The appropriations made or to be made for the purposes of carrying out the provisions of this article shall be available, in accordance with certificates of approval issued or to be issued by the director of the budget, to the state commissioner of health for the payment of expenses of personal service and other maintenance and operation, including purchase of equipment and the purchase of passenger automobiles and for travel outside the state, necessary for the administration of this article.

§ 56. Exceptions. Counties and cities shall not be entitled to state aid under the provision of this article for expenditures made covering the cost of care and treatment of tuberculosis patients in hospitals owned and operated by the state of New York.

§ 57. Procedure. The board of supervisors of each county or the common council or other body exercising similar powers of each city desiring to make application for state aid under this article shall on such dates as may be fixed by the state commissioner of health submit to him the request of such county or city for such state aid and shall support such request with such information as the state commissioner of health may require. The state commissioner of health shall prescribe the form in which such information shall be submitted.

§ 58. Application. All of the provisions of this article shall apply throughout the entire state and to each county and city thereof, including the city of New York.

§ 3. Section three hundred thirty-five of such chapter, as added by chapter four hundred eighty-one of the laws of nineteen hundred thirty-one, is hereby amended to read as follows:

[Section] § 335. *Continuation of Ray Brook state tuberculosis hospital and the establishment of three additional state tuberculosis hospitals. The New York state hospital for the treatment of incipent pulmonary tuberculosis shall hereinafter be known as the Ray Brook state tuberculosis hospital and is hereby continued for the care and treatment of tuberculosis. Whenever the term "the New York state Hospital for the Treatment of Incipient Pulmonary Tuberculosis" occurs or any reference is made thereto in this chapter or any other law, it shall be deemed to mean or refer to the Ray Brook state tuberculosis hospital.* [Three] *The three additional* state hospitals [in suitable localities within the state] for the care and treatment of tuberculosis [are hereby] established *pursuant to the authorization of chapter four hundred eighty-one of the laws of nineteen hundred thirty-one are hereby continued* under *the* jurisdiction and control of the state department of health[, and the]. *The state* commissioner of health shall determine the charge for the care and treatment of patients therein[, not greater than the actual cost of such care and treatment, which shall be paid by the county in which the patient resides] *as hereinafter provided.*

§ 4. Such chapter is hereby amended by inserting therein a new section, to be section three hundred thirty-six-a, to read as follows:

§ 336-a. Acquisition and operation by state of county or city tuberculosis hospitals. 1. Notwithstanding the provisions of any inconsistent general, special or local law or city charter, the state commissioner of health may, upon application by the board of supervisors of any county or the governing body of any city, assume responsibility to acquire as hereinafter specified for and on behalf of the state an existing tuberculosis hospital owned and operated by such county or city.

2. The state commissioner of health, upon receipt of such application, shall make such investigations as he may deem appropriate to protect the public health or other interests of the state. The state commissioner of health shall require such county or city to submit, within a period of thirty days after notice to that effect, a description of all lands then owned by the county or city for such tuberculosis hospital and any and all certificates or abstracts of title thereon, together with a description of the buildings and an inventory of all equipment, fixtures, supplies, furnishings, medical and household supplies, automotive equipment, and any other materials or property owned or possessed by such county or city for the maintenance, operation or use of such tuberculosis hospital.

3. When the state commissioner of health determines that the interest of the public health would be furthered by the continuance of such county or city tuberculosis hospital under state operation and administration, said county or city, following approval by the governor, shall transfer to the state, without cost, upon notice and on a date designated by the state commissioner of health, the title to all of the property and appurtenances constituting such county or city tuberculosis hospital, including all lands, buildings, equipment, fixtures, supplies, furnishings, medical and household supplies, automotive equipment, and any other materials or property assigned to or for the maintenance, operation or use of such hospital, as included in the inventory hereinbefore mentioned.

4. No outstanding bonded or other indebtedness shall be assumed by the state in the event of such transfer of title as aforesaid.

5. In the event that at any time subsequent to the taking of title by the state, the state commissioner of health determines that it is no longer economical or advisable for the state to continue the operation of such hospital, then, upon the discontinuance of such hospital by the state, the title to the land and buildings pertaining thereto shall, without obligation on the part of such county or city, revert to and be revested in such county or city.

§ 5. Sections three hundred thirty-nine and three hundred forty of such chapter, as added by chapter two hundred five of the laws of nineteen hundred thirty-four and amended by chapter seven hundred eighty-four of the laws of nineteen hundred forty-two, are hereby amended to read, respectively, as follows:

§ 339. Admission of patients. *1.* Patients shall be admitted to state tuberculosis hospitals in accordance with rules established by the state commissioner of health. The state commissioner of health shall from time to time designate the counties to be served by each such hospital, provided, however, that no county which maintains a county tuberculosis hospital shall hereafter be so designated unless the board of supervisors shall have so requested and any designation of such a county heretofore made shall cease to be effective July first, nineteen hundred forty-two. Any resident of a county thus designated by the state commissioner of health may apply in person to the superintendent of the hospital designated to serve the county in which he lives for admission to such hospital, or he may apply to any reputable physician for examination, and such physician, if he finds that such person is suffering from tuberculosis in any form, may apply to the superintendent of the hospital for his admission. Blank forms for such applications shall be provided by the superintendent and shall be forwarded by him gratuitously to any reputable physician, upon request, in any of the counties served by the hospital.

2. So far as practicable, applications for admission to the hospital shall be made upon such forms. The superintendent of the hospital, upon the receipt of such application, if it appears therefrom that the patient is suffering from tuberculosis, and if there be a vacancy in such hospital, shall notify the patient named in such application to appear in person at the hospital. If, upon examination of such patient, or of any patient applying in person for admission, the superintendent is satisfied that such person is a suitable case for treatment in such hospital, he shall admit him to the hospital as a patient subject to the rules established by the state commissioner of health. In the case of a patient admitted from one of the designated counties the superintendent shall within [forty-eight hours] *a reasonable time thereafter* of such admission send a notice to the clerk of the board of supervisors of such county.

3. The superintendent may admit patients [who are able to pay for their care and treatment] from any county within the state, but he shall give preference to those residing in the counties designated by the state commissioner of health to be served by such hospital [and who are unable to pay in whole or in part for their care and treatment]. The superintendent may also admit patients from any public tuberculosis hospital within the state upon the request of the chief medical officer of any such hospital to such state hospital in order to permit such patients to receive special medical or surgical care and treatment that any such hospital is unable to furnish but which is available at such state hospital.

§ 340. Maintenance of patients. *1.* The state commissioner of health shall fix the rate [of maintenance] to be charged [for each patient, which rate shall not exceed the average daily per capita cost of maintenance of six county tuberculosis hospitals. This cost shall be computed at least once a year from financial data obtained by the state commissioner of health at the time of the annual survey of county tuberculosis hospitals. After the admission of the patient to the hospital the superintendent shall cause an inquiry to be made as to the patient's financial circumstances, and of the relatives of the patient legally liable for his support. If he finds that such patient, or such relatives are able to pay for his care and treatment in whole or in part, an order shall be made for such patient or said relatives to pay to the treasurer of such hospital for the support of such patient a specified sum per week in proportion to their financial ability, but such sum shall not exceed the rate of maintenance fixed by the state commissioner of health. The superintendent shall have the same power and authority to collect such sum from the patient, his estate or his relatives legally liable for his support, as is possessed by a commissioner of public welfare in like circumstances. If the superintendent of the hospital finds that such patient or said relatives are unable to pay, either in whole or in part, for his care and treatment in such hospital the whole amount, or the part which he cannot pay, as the case may be, shall become a charge upon the county from which the patient was admitted. Upon request of the board of supervisors the superintendent shall send a written statement of his inquiry as to the financial circumstances of the patient and his relatives and the reasons for his decision that the patient or his relatives are unable to pay either in whole or in part for the care and treatment] *patients who voluntarily agree to pay for their care either in whole or in part. With the consent of the patient the state commissioner of health may alter such rate at any time.*

2. At least once in each month there shall be furnished to the clerk of the board of supervisors of each county a list of the patients in the hospital received from such county. Such list shall be accompanied by a bill [of necessary charges covering, in addition to the per diem cost, any items of expense of transportation, and the actual cost of necessary articles of clothing furnished by such hospital] *in the amount of fifty per centum of the unpaid balance of the patient per diem cost for each such patient, but such charge shall not exceed two dollars and fifty cents per day per patient.* [The] *Such* bill [therefor] shall be audited and paid by the board of supervisors of said county.

[After payment for the care and treatment of a patient by the board of supervisors of said county, such county or its board of supervisors may charge back to the county in which a patient may have a settlement the amount of such bill or bills. The county may sue for and collect from the patient, his estate or his relatives legally responsible for his support, any sum paid by said county to the state institution after investigation and determination that said patient, his estate or his relatives legally responsible for his support, are able to pay.]

§ 6. The title of article nineteen of such chapter, such article having been added by chapter four hundred eighty-one of the laws of nineteen hundred thirty-one, is hereby amended to read as follows:

ARTICLE 19

[STATE INSTITUTIONS IN THE DEPARTMENT] *NEW YORK STATE RECONSTRUCTION HOME AT WEST HAVERSTRAW*

§ 7. Section three hundred fifty of such chapter, as added by chapter four hundred eighty-one of the laws of nineteen hundred thirty-one and amended by chapter forty-two of the laws of nineteen hundred forty-one, is hereby amended to read as follows:

§ 350. Control of [state institutions in] *institution by* department of health. Subject to the provisions of the state finance law and the constitutional right of visitation and inspection of the state board of social welfare, the state department of health shall have jurisdiction, supervision and control of the New York state reconstruction home at West Haverstraw [and the New York State Hospital for the Treatment of Incipient Tuberculosis at Ray Brook].

§ 8. Sections three hundred fifty-five, three hundred fifty-six, three hundred fifty-seven, three hundred fifty-eight, three hundred fifty-nine, three hundred sixty and three hundred sixty-one of such chapter, as added by chapter four hundred eighty-one of the laws of nineteen hundred thirty-one, are hereby **repealed.**

§ 9. Section three hundred fifty-six-a of such chapter, as added by chapter six hundred twenty-eight of the laws of nineteen hundred thirty-eight, is hereby **repealed.**

§ 10. Section three hundred sixty-two of such chapter, as added by chapter four hundred eighty-one of the laws of nineteen hundred thirty-one, is hereby amended to read as follows:

§ 362. Appointment and removal of boards of visitors. Subject to the other provisions of this chapter, [each of said state institutions] *such home* shall continue to have a board of seven visitors, to be appointed by the governor by and with the advice and consent of the senate. The terms of office of such visitors shall be seven years, and they shall be so appointed that the terms of at least one of the members of such board shall expire on the first Tuesday of February of each year. All vacancies shall be filled by the governor in the same manner as original appointments, and the person appointed to fill a vacancy in the board of visitors of said [institutions] *institution* shall hold office for the remainder of the term of the person whom he succeeds. The governor may remove any member or members of a board of visitors for cause after an opportunity to be heard. This section shall not abridge the terms of the present members of such [boards] *board*.

§ 11. Section three hundred sixty-three of such chapter, as added by chapter four hundred eighty-one of the laws of nineteen hundred thirty-one, subdivision six thereof having been last amended by chapter forty-two of the laws of nineteen hundred forty-one, is hereby amended to read as follows:

§ 363. General powers and duties of [boards] *board* of visitors. [Boards] *The board* of visitors[, with respect to said institutions for which they are respectively appointed,] shall have the powers and duties expressly conferred or imposed on [them] *it* by this chapter and such other powers and duties not inconsistent with law, as may be prescribed by rules of the state commissioner of health. The visitors shall not receive any compensation for their services, but shall receive actual and necessary traveling and other expenses, to be paid after audit as other current expenditures of said institutions. [Each such] *Such* board shall, in October of each year, elect from among its members a president and secretary. The [superintendents] *superintendent* of said state [institutions] *institution* shall personally submit, at each monthly meet of its board of visitors, a report showing changes in population, health of inmates, officers and employees; accidents, suicides, unusual sickness, infectious diseases; important occurrences relating to the welfare of the inmates and to the management and discipline of the employees, and such other matters as the board of visitors may specify. [Each such] *Such* board shall:

1. Subject to such rules and the statutory powers of the commissioner, take care of the general interest of the institution and see that its design is carried into effect.

2. Maintain an effective inspection of the institution, for which purpose the board, or a majority of its members, shall visit and inspect the institution at least once each month. [Each] *The* board shall make a written report to the commissioner and to the governor within ten days after each inspection, such report to be signed by each member making the inspection. Such report shall state in detail the condition of the institution and of its inmates, and such other matters pertaining to the management and affairs thereof as in the opinion of the board of visitors should be brought to the attention of the commissioner of health or the governor, and may contain recommendations as to needed improvement in the institution or in its management. Members of [boards] *the board* of visitors who fail to attend the meetings of [their respective boards] *the board* or fail to make such visitations for three successive months, shall be deemed to have vacated their membership in such [boards] *board* of visitors, whereupon the governor shall fill the vacancies so created as provided by law, unless the absence of such visitors shall be excused by the governor.

3. Keep in a book provided for that purpose, a fair and full record of [their] *its* doings, which shall be open at all times to the inspection of the governor or of any person appointed by the governor or by either house of the legislature, to examine the same, and of the state commissioner of health or his authorized representatives.

4. Hold regular meetings at least once each month, and cause to be typewritten within ten days after each such meeting, the minutes and proceedings of such meeting, and cause a copy thereof, to be sent forthwith to each member of the board of visitors, to the commissioner of health and to the governor.

5. Enter in a book, kept at the institution for that purpose, the date of each visit of each visitor.

6. Make to the state commissioner of health in January of each year, a detailed report of the results of [their] *its* visits and inspection, with suitable suggestions and such other matters as may be required of [them] *it* by the state commissioner of health for the year ending on the thirty-first day of December preceding the day of such report. Such report shall be prepared by a committee of the board of visitors, subject to the approval of such board.

7. Investigate, hear and ascertain the truth of all charges made against the superintendent or other officer or employee of the institution, issue subpoenas, take and hear testimony in respect to such charges and make its recommendations thereon to the authority having the power to discharge or remove. A witness attending before such board shall be entitled to the same fees as a witness attending before a court of record or a judge thereof, which shall be paid as other institutional charges. The resident officers shall admit such visitors into every part of the institution and its buildings, and exhibit to them on demand all the books, papers, accounts and writings belonging to the institution, or pertaining to its business, management, discipline or government, and furnish copies, abstracts and reports whenever required by them.

§ 12. Section three hundred sixty-four of such chapter, as added by chapter four hundred eighty-one of the laws of nineteen hundred thirty-one, is hereby amended to read as follows:

§ 364. [Superintendents of institutions] *Superintendent.* There shall be a superintendent of [each] said state institution. Such superintendent shall be in the competitive class of the civil service, and shall be appointed by the state commissioner of health, whenever there is a vacancy. Such superintendent shall have the qualifications prescribed by law, or, if no such qualifications be prescribed, such qualifications as may be prescribed by the public health council. Before making the appointment, the commissioner of health shall give notice, by registered mail, to the members of the board of visitors, of his intended action, naming the person whom he proposes to appoint and his place of residence, and shall specify a day, not less than ten days from the mailing of the notice, before which the board of visitors may submit to the state commissioner of health the objections of the board of visitors, if any, to such appointment; and the person named shall not be appointed before such day, except in the case of an express approval by the board of visitors. [Superintendents] *The superintendent* of said [institutions] *institution* now in office [are] is continued in office, subject to removal in the manner provided in this section. The superintendent may be removed by the state commissioner of health for cause stated in writing, after an opportunity has been given the superintendent to be heard thereon, and such action by such commissioner shall be final. The board of visitors, however, shall be notified of any such hearing and its members be given an opportunity to be heard thereat. Pending the investigation by the state commissioner of health or board of visitors of any charges against a superintendent, the commissioner may suspend such superintendent. The state commissioner of health may prefer charges of misconduct or incompetency against [any] *the* superintendent to the board of visitors, and the board of visitors shall thereupon investigate the truth of such charges and make its recommendations thereon to the commissioner or the commissioner may investigate, or cause the head of a division to investigate any charges of like nature made to the commissioner, and for that purpose the investigating authority may subpoena witnesses and take and hear testimony.

§ 13. Section three hundred sixty-five of such chapter, as added by chapter four hundred eighty-one of the laws of nineteen hundred thirty-one, is hereby amended to read as follows:

§ 365. Powers and duties of the superintendent, generally. Subject to rules of the state commissioner of health, the

superintendent of [each] such state [institutions] *institution* shall have the management of the institution and, except as otherwise provided with respect to the treasurer, shall appoint all subordinate officers of the institution; and they shall be removable by him in accordance with the civil service law and rules. In other respects, the superintendent shall have the powers and duties prescribed by law [for the superintendent of the institution under his charge], to be exercised and performed, however, subject to rules of the state commissioner of health. Nothing in this chapter shall prevent the adoption by [any] *such* superintendent of rules pertaining to duties of officers and employees of the institution under his charge or for the internal government, discipline and management of the institution, consistent with rules of the state commissioner of health, but any such rule of the superintendent shall be subject to revocation or suspension by the state commissioner of health.

§ 14. Section three hundred sixty-five-a of such chapter, as added by chapter one hundred six of the laws of nineteen hundred forty, is hereby amended to read as follows:

§ 365-a. Designation of employees as special policemen; powers and duties. The superintendent of [each] *such* state institution [in the department] may designate attendants or other employees to act as special policemen whose duty it shall be under the orders of the superintendent to fully protect the grounds, buildings and patients of the institution and to eject therefrom disorderly persons. Such attendants and employees, acting as policemen, shall possess all the powers of peace officers on the grounds and premises and to the extent of one hundred yards beyond such grounds. The designation of such attendants and employees as special policemen, in pursuance hereof, shall not be deemed to supersede, on the grounds and premises of such institution, the authority of peace officers of the jurisdiction within which such institution is located.

§ 15. The section heading and opening paragraph of section three hundred sixty-six of such chapter, such section having been added by chapter four hundred eighty-one of the laws of nineteen hundred thirty-one, are hereby amended to read as follows:

[Treasurers of institutions] *Treasurer;* powers and duties. [Each such] *Such* state institution shall have a treasurer. The state commissioner of health may appoint such an officer for such [institutions] *institution,* but the superintendent of an institution shall be its treasurer if such an appointment is not made, or pending an appointment to fill a vacancy, and he shall perform the duties of treasurer during the absence or disability of the person, if any, so appointed. Subject to rules and regulations of [such] *the* state commissioner of health, the treasurer shall,

§ 16. Section three hundred sixty-a of such chapter, as added by chapter seven hundred sixty-nine of the laws of nineteen hundred forty-four, is hereby amended to read as follows:

§ 366-a. Use of laboratory service by municipal and county officials. Subject to the approval of the state commissioner of health, the superintendent of [any] such state institution may enter into a contract with proper municipal or county officials under which the laboratory service of such institution may be made available to municipalities or counties or parts thereof when in his judgment such a contract will be in the interest of public health and not prejudicial to the interest of the institution or its works. The treasurer of such institution shall receive all moneys paid in consideration of such contract and pay the same into the general fund of the state.

§ 17. Sections three hundred sixty-seven and three hundred sixty-eight of such chapter, as added by chapter four hundred eighty-one of the laws of nineteen hundred thirty-one, are hereby amended to read, respectively, as follows:

§ 367. Oaths and bonds. Each visitor, superintendent and treasurer of such state [institutions] *institution* shall take the constitutional oath of office. The treasurer of [each] such institution shall give a bond in such amount as the comptroller may direct. An additional bond or bonds may be required at any time of [a] *the* treasurer [who] *if he* disburses money accruing from gifts, to secure his faithful discharge of that duty. The [costs] *cost* of any such bond shall be paid from funds appropriated to the use of the institution.

§ 368. Admission to [institutions] *institution.* Subject to the provisions of this chapter relative to the said state [institutions] *institution* the department may establish rules and regulations governing the admission of inmates to such [institutions] *institution.* If in the judgment of its superintendent the number of inmates of [any] such institution at any time so far exceeds its proper capacity that suitable care, training or discipline cannot be given to additional inmates, or for other reasons the admission of such additional inmates, is impracticable, the state commissioner of health, in his discretion, may suspend the admission of inmates to such institution until such time as they may properly be admitted.

The commissioner of health shall promptly notify courts and other public officers empowered to commit persons to such [institutions] *institution* of any such suspension of admission and of its termination. A person committed to such institution before the court receives notice of such a suspension may be recommitted to another institution to which he or she might have been lawfully committed in the first instance.

In the admission of inmates to the said state [institutions] *institution* the several counties and the city of New York shall, so far as practicable, be entitled to have in such [institutions] *institution* inmates in the ratio which their respective populations bear to the population of the state as ascertained by the latest federal census.

§ 18. Chapter sixteen of the laws of nineteen hundred nine, entitled "An act in relation to counties, constituting chapter eleven of the consolidated laws," is hereby amended by inserting therein a new section, to be section forty-nine-bb, to read as follows:

§ 49-bb. Applications to state commissioner of health. On and after January first, nineteen hundred forty-seven, whenever a person alleged to be suffering from tuberculosis is unable to gain admission to an appropriate tuberculosis hospital for necessary diagnostic or treatment services, such person may make application to the state commissioner of health for admission to an appropriate tuberculosis hospital for such services, treatment and care. The cost of such services and treatment and of the maintenance of such patient shall be subject to the provisions of section fifty-four and other applicable provisions of the public health law.

§ 19. Section forty-nine-f of such chapter, as added by chapter four hundred eighty-four of the laws of nineteen hundred forty-two, is hereby amended to read as follows:

§ 49-f. Abolition of county tuberculosis hospital; procedure. *1. The board of supervisors of any county in which there is a county tuberculosis hospital established pursuant to the authorization in this article or any other general or special law shall continue the operation of such hospital, except as hereinafter provided.*

2. Notwithstanding the provisions of this article, or of any other general or special law, the board of supervisors of any county maintaining a county tuberculosis hospital may request the state commissioner of health to *assume responsibility for the operation and maintenance of such hospital as a state tuberculosis hospital or to* authorize the abolition of [said] *such* county tuberculosis hospital [and, after investigation by him, the said commissioner of health]. *The state commissioner of health, upon receipt of such application, shall make such investigations as he may deem appropriate to protect the public health or other interests of the state. Following such investigation, he* may certify in writing to the board of supervisors of such county that such county can be adequately served by a state tuberculosis hospital and that in his opinion the continued operation of such county tuberculosis hospital is unnecessary. On receipt of any such certification the board of [supervisor] *supervisors* is hereby authorized to abolish such hospital by resolution adopted by a majority vote of the

members of such board. On the abolition of any such hospital the board of supervisors may dispose of the property and equipment thereof or direct the same to such other public use as is deemed desirable within the limits prescribed by law. Such board may dispose of funds, or other property held in trust pursuant to subdivision five of section forty-five as is permitted by law and the terms of any bequests relating thereto. The terms of office of the board of managers or other governing body and the superintendent thereof shall automatically terminate on the abolition of any such hospital. *However, the state commissioner of health, following such investigation, may, with the approval of the governor, notify such county board of supervisors that, for the protection of the public health, such hospital should be continued as a tuberculosis hospital under state ownership and operation to serve, in addition to such county, such other counties as may require tuberculosis hospital or chest clinic service.*

3. When the state commissioner of health determines that the interest of the public health would be furtherd by the continuance of the service of such county tuberculosis hospital under state ownership, operation and administration, said county shall be required to submit, within a period of thirty days after notice to that effect, a description of all lands then owned by the county for such tuberculosis hospital and any and all certificates or abstracts of title thereon, together with a description of the buildings and an inventory of all equipment, fixtures, supplies, furnishings, medical and household supplies, automotive equipment, and any other materials or property owned or possessed by the county for the maintenance, operation or use of such hospital, and upon notice and on a date designated by the state commissioner of health, said county shall transfer to the state, without cost, the title to all of the property and appurtenances constituting such county tuberculosis hospital, including all lands, buildings, equipment, fixtures, supplies, furnishings, medical and household supplies, automotive equipment, and any other materials or property assigned to or for the maintenance, operation or use of such hospital, as included in the inventory hereinbefore mentioned.

4. No outstanding bonded or other indebtedness shall be assumed by the state in the event of such transfer of title as aforesaid.

5. In the event that at any time subsequent to the taking of title by the state, the state commissioner of health determines that it is no longer economical or advisable for the state to continue the operation of such hospital, then, upon the discontinuance of such hospital by the state, the title to the land and buildings pertaining thereto shall, without obligation on the part of such county, revert to and be revested in such county.

§ 20. This act shall take effect July first, nineteen hundred forty-six, except that section two of this act shall take effect January first, nineteen hundred forty-seven.

REGIONS, DISTRICTS AND CENTERS SUGGESTED BY MOUNTIN, PENNELL AND HOGE, (UNITED STATES PUBLIC HEALTH SERVICE)

Joseph A. Mountin, Medical Director; Elliott H. Pennell, Senior Statistician; and Vane M. Hoge, Senior Surgeon, of the United States Public Health Service, have drawn up a tentative plan of health service areas for each state. They generously made their data available to the Commission prior to publication. Their plan for New York State, Figure 14, sets forth four "Primary Centers"—in Buffalo, Syracuse, Albany and New York City. Secondary districts and centers are also set up, based in part on existing general hospital bed facilities and in part on information regarding natural trade areas. The regions and districts follow county boundaries. The primary centers, selected in this plan, are cities having 250 or more general and special hospital beds,[33] some of which are in hospitals approved by the American College of Surgeons. When there was a choice to be made between two or more possible centers, the one with the greatest concentration of hospital beds was selected. Secondary districts are composed of counties surrounding secondary centers, which are cities containing 100–249 general and special hospital beds.

The authors frankly declare that their plan "is neither an expression of policy . . . nor a forecast of what is to come. If the funds and the will to proceed on any plan for extending hospital service in a comprehensive way should eventuate, many adjustments would be in order. For those who, now or later, may have administrative responsibilities in this broad area of social interest, perhaps the monograph may serve as a point of departure."

The regional plan for New York State suggested by Mountin, Pennell and Hoge, would expect residents in or near Rochester to travel to Buffalo for special hospital services which are already available in Rochester. The necessity for excluding the latter city as a Primary Center is not evident. Also, it would seem unreasonable to require residents of Tioga, Broome and Chenango Counties to travel for special hospital services to New York City, when Syracuse is more readily accessible. Similarly, Albany is a much nearer Primary Center for Delaware County than is New York City, in which it is allocated in the plan.

Designed as it is for general application throughout the United States, the regional hospital plans of Mountin and his associates are necessarily based upon the location of primary centers in cities having a relatively large number of general hospital beds. However, New York State is unusually fortunate in that to this criteria can be added that of the existence of the superior facilities associated with a medical school or university, this providing it with the five "natural" centers at Buffalo, Rochester, Syracuse, Albany, and New York City. These have been retained in the plan proposed by the Commission.

[33] Including hospitals operated by the Bureau of Indian Affairs; excluding other Federal hospitals, mental hospitals, tuberculosis hospitals, and infirmary units of correctional and custodial institutions.

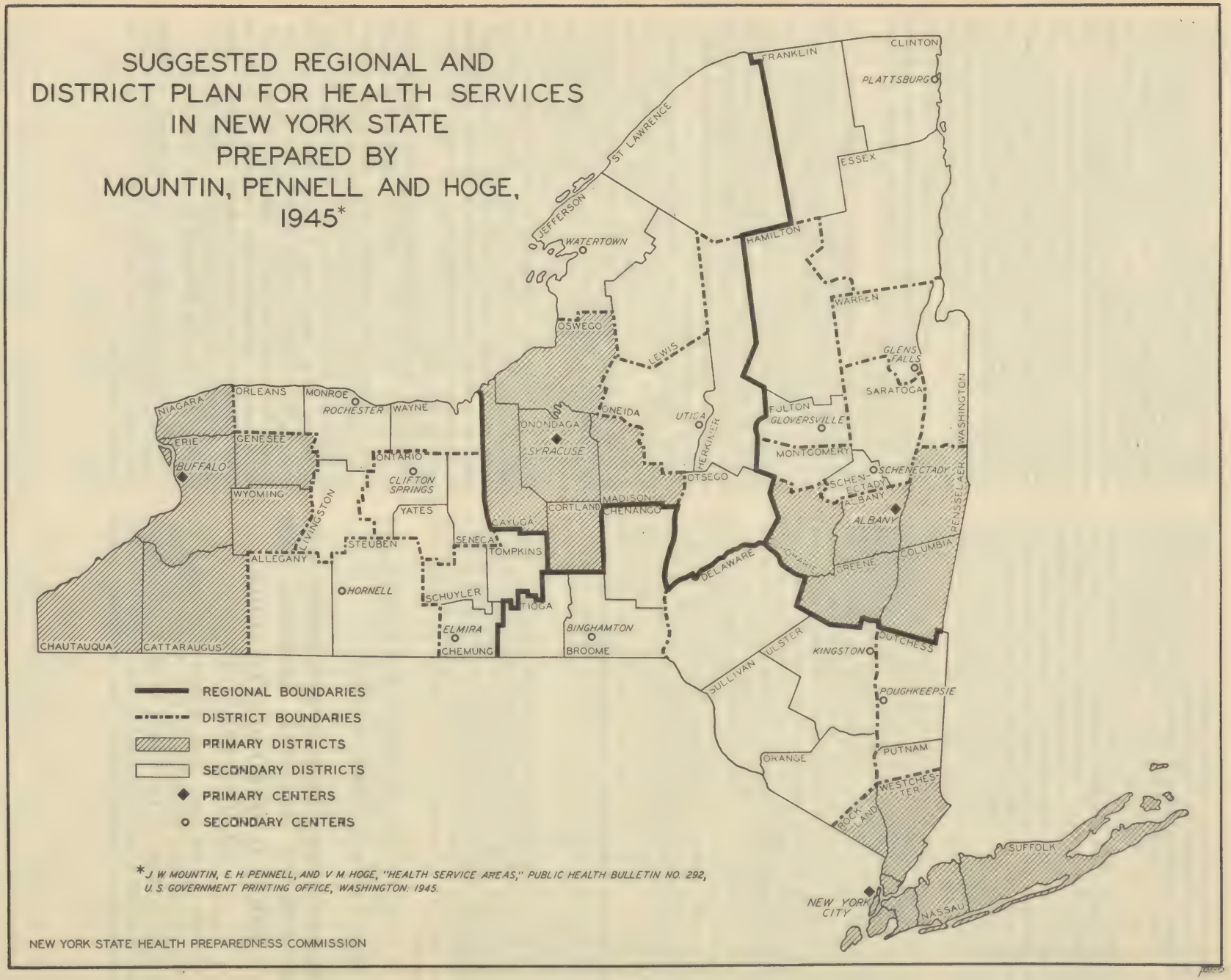

SUGGESTED REGIONAL AND
DISTRICT PLAN FOR HEALTH SERVICES
IN NEW YORK STATE
PREPARED BY
MOUNTIN, PENNELL AND HOGE,
1945*
FRANKLIN
CLINTON
PLATTSBURG
ST LAWRENCE
ESSEX
JEFFERSON
WATERTOWN
HAMILTON
WARREN
OSWEGO
LEWIS
GLENS FALLS
SARATOGA
NIAGARA
ORLEANS
MONROE
ROCHESTER
WAYNE
ONEIDA
UTICA
HERKIMER
FULTON
GLOVERSVILLE
WASHINGTON
ERIE
GENESEE
ONONDAGA
SYRACUSE
MONTGOMERY
BUFFALO
ONTARIO
CLIFTON SPRINGS
OTSEGO
SCHENECTADY
WYOMING
LIVINGSTON
YATES
CORTLAND
MADISON
CHENANGO
ALBANY
RENSSELAER
CAYUGA
STEUBEN
SENECA
TOMPKINS
DELAWARE
COLUMBIA
ALLEGANY
GREENE
HORNELL
SCHUYLER
TIOGA
BINGHAMTON
ELMIRA
CHEMUNG
BROOME
CHAUTAUQUA
CATTARAUGUS
SULLIVAN
ULSTER
KINGSTON
DUTCHESS
POUGHKEEPSIE
ORANGE
PUTNAM
ROCKLAND
WESTCHESTER
SUFFOLK
NEW YORK CITY
NASSAU
REGIONAL BOUNDARIES
DISTRICT BOUNDARIES
PRIMARY DISTRICTS
SECONDARY DISTRICTS
PRIMARY CENTERS
SECONDARY CENTERS
*J. W. MOUNTIN, E. H. PENNELL, AND V. M. HOGE, "HEALTH SERVICE AREAS," PUBLIC HEALTH BULLETIN NO. 292, U. S. GOVERNMENT PRINTING OFFICE, WASHINGTON: 1945.
NEW YORK STATE HEALTH PREPAREDNESS COMMISSION

FIGURE 14

STATE OF NEW YORK

Nos. 1533, 1924, 1981, 2156 **Int. 1296**

IN SENATE

March 25, 1920

Introduced by Mr. SAGE—read twice and ordered printed, when printed to be committed to the Committee on Finance—committee discharged, said bill amended, ordered reprinted as amended, and when reprinted to be recommitted to said committee—committee discharged, said bill amended, ordered reprinted as amended, and when reprinted to be recommitted to said committee—committee discharged, said bill amended, ordered reprinted as amended, and when reprinted to be recommitted to said committee.

AN ACT

To amend the public health law, so as to provide for residents of rural districts, for industrial workers and for all others who cannot otherwise secure such benefits, adequate and scientific medical and surgical treatment, hospital and dispensary facilities and nursing care, to assist local medical practitioners, and in general to improve the health of the inhabitants of the state by authorizing a county, city or health district to create and maintain one or more health centers, to provide state aid for same, and making an appropriation therefor.

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Article three of chapter forty-nine of the laws of nineteen hundred and nine, entitled "An act in relation to public health, constituting chapter forty-five of the consolidated laws," is hereby amended by inserting therein four new sections to be known as sections twenty-b, twenty-c, twenty-d and twenty-e and to read as follows:

§ 20-b. Health districts. The board of supervisors of any county, with the approval of the state commissioner of health, shall have the power to establish such county, or any part or parts thereof, as a health district and in such event shall appoint a board of health for each of such districts. Provided, however, that no city or any part thereof shall be included as part of any such health district unless the mayor and common council, or the officials exercising similar powers, shall have consented thereto. The board of health shall consist of five members, at least one of whom shall be a graduate of at least three years' standing of a medical college. The term of office of each member of said board shall be five years and the term of one of the members shall expire annually. The first appointments shall be made for the respective terms of five, four, three, two and one years. The members of the board shall receive no compensation for their services but shall be allowed their actual and necessary traveling expenses, to be audited and paid in the same manner as the other expenses of the county. When such board of health has been established it shall within its district exercise all the powers and perform all the duties of local boards of health conferred by any law or laws or by the state sanitary code.

Such board of health shall appoint a district health officer who shall possess such qualifications as may be prescribed by the public health council. Such district health officer shall serve for a term of six years and shall devote his whole time to the duties of his office except as hereinafter authorized. He shall within his district possess all the powers and duties conferred upon local health officers by any law or laws, or by the state sanitary code. The salary of such district health officer shall be fixed by the board of health of such district.

Local health districts now existing within such health district so established by the board of supervisors shall continue to exist as subdivisions of the health district. Local boards of health within such district shall continue to exist and to retain their present powers and duties subject to the rulings and ordinances of the district health board and shall continue to appoint health officers for such local districts, as now provided by law. The board of supervisors shall have power within any health district established as hereinbefore provided to consolidate with adjoining districts all local health districts having a population of less than one thousand. When such consolidation has been ordered by the board of supervisors the same steps shall be taken and the same rights and duties devolve upon all persons as ensue upon the signing of the order for consolidation by the state commissioner of health as provided for in sections twenty and twenty-a of this act. Provided, however, that no consolidation so ordered shall take effect until the expiration of the terms of the local health officers affected who are in office on the first day of July, nineteen hundred and twenty, unless with the consent of such local health officers. The local health officers within the health districts when established shall act as deputies to the district health officer. They shall, subject to the supervision of the district health officer, perform within their local districts all of the duties of local health officers and shall serve for the same terms and under the same conditions as now are, or hereafter may be, prescribed by law. Present local health officers in office at the time of the passage of this act shall act as such deputies during their present term of office and shall be eligible for reappointment if they have complied with the qualifications of the public health council, and hereafter no

EXPLANATION—Matter in *italics* is new; matter in brackets [ ] is old law to be omitted.

one shall be appointed as local health officer unless he has complied with the qualifications prescribed by the public health council or has been duly exempted from said qualifications by the said council.

§ 20-c. Health centers. The board of supervisors of any county may establish therein a health center or centers which shall serve the whole or part of the county. In the resolution of the board of supervisors establishing such health center they shall define the area which it is intended to serve. Provided, however, that no city or any part thereof shall be included in the area so defined unless the mayor and common council, or the officials exercising similar powers, shall have consented thereto. Such board when it has decided to establish a health center shall formulate a general plan for the same which may include any one or more of the parts hereinafter set forth, any one or more of which may be established at any one time:

a. For the erection of hospitals or for arrangements with existing hospitals or other institutions, health centers or districts, or both, so that they shall form essential parts of the health center. Such hospital provision may include as units thereof hospitals or other kindred institutions now existing, or hereafter established, and special pavilions for the care of tuberculosis and other communicable diseases, and for children, maternity cases, for mental diseases and other groups of diseases.

b. Clinics for outpatients, including especially those now regarded as public health clinics, such as maternity, prenatal and child welfare clinics, those for tuberculosis and venereal disease, mental and nervous diseases and defects, clinics for school children, dental clinics, and also general medical, surgical and diagnostic clinics.

c. For clinical, bacteriological, X-ray and chemical laboratories auxiliary to the state laboratories affording modern laboratory facilities needed in the diagnosis and treatment of disease, with services at a moderate charge or free if the person served is found by the superintendent of the health center to be unable to pay in accordance with the procedure hereinafter set forth in paragraph number six of the duties of the superintendent.

d. For public health nursing service for all parts of the district.

e. For cooperation with the state department of education in securing proper medical supervision and medical inspection for school children and assisting in providing the facilities to enable practitioners to secure adequate treatment for all school children showing physical defects or disease.

f. For periodical medical examination of such inhabitants of the district as desire it and are willing to pay a proper charge therefor.

g. For headquarters for all other public health, medical, nursing and other public welfare agencies of the district which wish to utilize the same.

The location, site, plans and initial fixed equipment and subsequent additions thereto or modifications thereof of the health center and of any part or parts thereof shall be subject to the approval of the state commissioner of health. The state commissioner of health and the state architect shall provide model plans for such centers for any community requesting the same. The board of supervisors when they shall have determined to establish such health district shall have the following powers:

1. To purchase, sell, exchange or lease real property therefor or acquire such real property and easements therein. Provided, however, that no such property shall be purchased or acquired until such purchase or acquisition shall have been approved by the state commissioner of health.

2. To enter into contacts for the erection of all necessary buildings and the alteration of any buildings on the property when acquired for the use of such health center or any part or parts thereof.

3. To cause to be assessed, levied and collected such sums of money as it shall deem necessary for suitable lands, buildings and improvements for such health center, or part or parts thereof, and for the maintenance thereof, and for all other necessary expenditures. Provided, however, that where the health center is intended to serve less than a whole county the expenditures made in connection therewith shall be assessed only against the district served by the health center. Said board of supervisors shall also have power to borrow money for the erection of such health center, or parts thereof, and for the purchase of a site therefor on the credit of the county and issue county obligations therefor in the same manner as it may do for other county purposes.

4. To accept and hold in trust for the county any grant or devise of land or any gift or bequest of money or other personal property or any donation to be applied, principal or income, or both, for the benefit of the said health center or any part or parts thereof.

5. To appoint a board of managers of the health center which shall consist of eight members one of whom shall be the county judge ex officio, and one of whom shall be the president of the board of health ex officio. Where a health district has not been established as provided for in section twenty-b of this act the board of managers shall consist of seven members and the county judge shall be the only ex officio member thereof. Of the others at least one shall be a woman and two shall be physicians duly licensed to practice in the state of New York. The board shall hold a meeting at least once each month and for each regular meeting each member attending shall receive the sum of five dollars and his or her actual and necessary travelling expenses, to be audited and paid in the same manner as the other expenses of the health center. Special meetings may be called from time to time in such manner as the by-laws may provide. For attendance at such special meetings no fees shall be paid to members. The members of such board, with the exception of the members ex officio, shall be first appointed so that the term of one member shall expire within one year from the first day of January of the year in which he shall have been appointed, the term of another member shall expire within two years from the first day of January of the year in which he shall have been appointed, the term of another member shall expire within three years from the first day of January of the year in which he shall have been appointed, the term of another member shall expire within four years from the first day of January of the year in which he shall have been appointed, the term of another member shall expire within five years from the first day of January of the year in which he shall have been appointed, and the term of the remaining member shall expire within six years from the first day of January of the year in which he shall have been appointed. Thereafter, the terms of membership shall be made for six years from the first day of January of the year in which the appointment is made.

The board of managers of each health center shall have the following powers and duties:

1. To appoint a superintendent of the health center, or any part thereof, who may also be secretary and treasurer of the board of managers. The district health officer may be appointed as such superintendent. Any person appointed as such superintendent shall comply with the qualifications prescribed by the public health council.

2. To fix the salaries of the superintendent of the health center and of all other officers and employees, within the limits of the appropriations made therefor by the board of supervisors.

3. To exercise general management and control of said health center, of the grounds, buildings, officers, attending physicians, employees and inmates thereof, and of all matters relating to the government, discipline, contracts and fiscal concerns thereof.

4. To make such rules and regulations as may be advised by the medical board as necessary for the medical and surgical care and treatment of patients and for the study of the nature and cause of death in cases terminating fatally. They shall make rules and regulations regulating the fees to be charged for all medical and surgical services in such hospital, and fixing the salaries of attending physicians and all other rules and regulations necessary for the carrying into effect of the purposes of such health center. It is the purpose of this act

to provide, through the co-ordinated work of experts in the different departments of medical practice, adequate facilities for accurate diagnosis and efficient treatment of disease. Boards of managers are directed to carry this purpose into effect so far as practicable. Physicians and surgeons rendering services in hospitals and clinics shall be properly compensated for their services and boards of managers shall see that such compensation is provided.

5. Notwithstanding any other general or special law, to erect all additional buildings found necessary after the health center has been placed in operation and make all necessary improvements and repairs within the limits of the appropriations made therefor.

6. To employ, within the limits of its appropriations, public health nurses for the discovery of cases of communicable or other diseases, for the visitation of such cases and of patients discharged from the health center hospital or from any other part of such health center, and for the performance of such other duties as may seem proper.

7. To appoint a medical board which shall have charge of the medical and surgical affairs of the health center.

8. To appoint and employ, after consultation with the medical board, all members of the medical, surgical and laboratory staff of the health center. All persons appointed to such positions shall comply with such requirements as may be prescribed by the public health council.

The superintendent of such health center shall be the executive officer of all hospitals, clinics, laboratories and other activities of the health center and, subject to the board of managers and of the health center and, subject to the board of managers, shall:

1. Equip the health center hospital and all other parts of such health center with all necessary furniture, appliances, fixtures and other needed facilities for the care and treatment of patients and for the use of officers and employees thereof, and purchase all necessary supplies within the appropriations made therefor.

2. Have general supervision and control of the internal affairs of the health center and maintain discipline therein and enforce compliance with and obedience to all rules, by-laws and regulations adopted by the board of managers for the government and control of such health center and the employees and inmates thereof. He shall make and enforce such further rules, regulations and orders as he may deem necessary, not inconsistent with law or with the rules and regulations of the board of managers.

3. Appoint such other employees as he may think necessary and proper within the limits of his appropriations, except the attending physicians.

4. Cause proper accounts and records of the business and operation of the health center to be kept; certify all bills and accounts including salaries and wages, and transmit them to the board of supervisors which shall provide for their payment in the same manner as other charges against the county.

5. Receive, subject to the rules and regulations of the board of managers of the health center, into such health center, or to any part thereof, in order of application, or treat in such clinics, dispensaries, et cetera, any person in the health district who is in need of medical or surgical care, irrespective of whether such person is able to pay for such care or not. He may also receive or treat persons from without the said health district under such conditions as may be prescribed by the board of managers, provided there is a vacancy therein and provided the reception or treatment of such person does not interfere with the proper care and treatment of persons received from the district.

6. Cause to be made such inquiry as he may deem necessary as to the ability of each patient, or the relatives of such patient legally liable for his support, to pay for his care and treatment. If he shall find that such person, or said relatives, are able to pay for such care and treatment in whole or in part an order shall be made by the superintendent directing the patient or said relatives to pay to the treasurer of said health center for the support or treatment of such person a specified sum per week in proportion to their financial ability, but not in excess of the actual cost of maintenance. He shall have the same power and authority to collect such sum from the patient or his relatives legally liable for such support as is possessed by an overseer of the poor. If the superintendent finds that such patient or said relatives are able to pay only in part, or not at all, for the care and treatment in said hospital, the unpaid cost of maintenance or treatment shall become a charge upon the county or district. Provided, that in case such patient has not acquired a settlement within such health district under the provisions of the poor law, the superintendent of such health center shall collect from the town, city, village or health district in which such person has a settlement the cost of his maintenance, or may in his discretion return such patient to the town, city, village, county or health district in which he has a settlement. No employee of such health center, except physicians, shall receive or accept from any patient thereof any fee, payment or gratuity whatsoever. Any physician who has been attending any patient prior to such patient's admission to the hospital of the health center shall be allowed, if the patient so desires, to continue such treatment while the patient remains in the hospital.

7. Cause to be kept proper records of the admission and treatment of each patient, including name, age, sex, color, marital relation, residence, occupation, place of last employment and the names and addresses of his or her nearest relatives. He shall also cause a careful examination to be made and recorded of the physical condition of all persons admitted to or treated at the hospital and shall cause a record to be kept of the condition of such patient during treatment and when discharged and from time to time thereafter.

8. Discharge from such hospital or cease to provide treatment for any patient who is found to have recovered sufficiently from his illness no longer to be in need of hospital care, or other treatment, or who shall violate willfully or habitually the rules or who for any reason is no longer a suitable person for treatment.

9. Collect and receive all moneys due the health center, keep an accurate account of the same and report the same to the monthly meeting of the board of managers and transmit the same within ten days after such meeting to the treasurer of the county.

10. Give a bond before entering upon the discharge of his duties, in such sum and with such securities as the board of managers may approve, to secure the faithful performance of his duties. Nothing in this section contained shall be construed to repeal, alter or amend any of the provisions of sections one hundred and twenty-six to one hundred and thirty-four, inclusive, of the general municipal law in cities where there are now existing hospitals operating under said sections of the general municipal law. If boards of managers appointed pursuant to said provisions of the said general municipal law are also operating health centers or dispensaries in connection with existing hospitals at the time this bill is passed, such boards of managers shall continue to function and cities involved shall automatically become health center districts and the boards of managers shall become health center boards of managers as defined in this act. If such board of managers desires to avail itself of the state aid hereinafter provided for it shall have the construction of its buildings and its plans and operation first approved by the state commissioner of health.

The board of managers of any health center already established, with the approval of the board of health of a county or the authority having jurisdiction over the health center in a city and the state commissioner of health may establish subcenters if the area to be covered by the center is so large and its topography is such as to make access to the center difficult or for any other reason such action seems necessary or desirable. Such subcenter may contain any one or more parts of the health center as described in section twenty-c, excepting the laboratory therein provided for.

§ 20-d. Health centers in cities. If a city desires to avail itself of the state aid provided for in section 20-e of this act,

the common council or any other body exercising similar duties in any city with the approval of the board of estimate if such exists in such city, and the board of estimate and apportionment in the city of New York, shall have the power, with the approval of the state commissioner of health, to establish a health center or centers in such city and to define the limits thereof. Upon the establishment of such health center by such city all the powers and duties herein provided for in relation to health centers shall devolve upon the corresponding officials of the city, excepting that the mayor shall appoint the members of the board of managers of such health center and the board of health of such city, if there be such board of health, and the health officer thereof shall be appointed as now or hereafter provided for by law and the salaries of officials and employees of the health center and contracts to be made by or on behalf of the health center, and the issuance of bonds for the health center shall all be under the control of the same officials as now have the control of the other salaries, contracts and bonds of the city, and shall be governed by the same provisions of law. All of the provisions of section twenty-c hereof shall apply in so far as practicable to health centers when established in cities, provided, however that the offices of health officer, and superintendent of the health center and the board of health and the board of managers may be consolidated into one office or one board with the approval of the state commissioner of health, which approval may be rescinded by the said state commissioner of health at any time, in which event the provisions of section twenty-c, in so far as applicable, shall apply to such city.

§ 20-e. State aid. Where such health district or health center shall have been established with the approval of the state commissioner of health, the state, through the legislature, shall provide the following aid:

a. For the construction and equipment of hospitals one-half of the cost thereof, such payment not to exceed seven hundred and fifty dollars per bed established in such hospital, and for this purpose no aid shall be granted from the state for beds in excess of one to each five hundred of the population affected.

b. A grant of seventy-five cents per day for each free patient maintained in any hospital operated as a part of such health center.

c. A grant for the establishment of each outpatient clinic or sub-center of the health center equal to one-half of the cost of installation, the amount to be paid by the state for this purpose not to exceed five thousand dollars per clinic.

d. A grant towards the ordinary current expenditures for free treatments, in such clinic not to exceed fifty per centum of such cost and not to exceed an average of twenty cents per treatment.

e. A grant of one-half of the actual cost of maintenance of the laboratory and laboratories of health centers not in excess of three thousand dollars per annum for each laboratory and of fifteen hundred dollars towards the initial installation and equipment of such laboratory.

f. A grant of ten cents per capita per annum towards the salaries of deputy health officers in such health districts where the local district has less than fifteen hundred population, and of five cents per capita per annum towards the salaries of deputy health officers in local districts having a population between fifteen hundred and three thousand, in addition to such salaries as they are entitled to receive from the local treasurer.

Provided, however, that no state aid in excess of the above specified amounts shall be granted hereunder in counties or districts having more than fifty thousand population if more than one health center is established for each fifty thousand inhabitants, or major fraction thereof.

It is the intention of this act to provide additional hospital and clinical facilities and, therefore, no grant from the state hereinbefore provided for shall be given to any public institution which is already established at the time of the passage of this act, excepting clinics especially established for prenatal, maternity and postnatal care, and those for children, tuberculosis and venereal diseases.

The salaries and traveling expenses of consultants, experts and other employees of the state department of health, and other expenses necessarily incurred by the state department of health in the execution and enforcement of this act shall be paid from the sum appropriated for grants towards maintenance and operation of health centers as hereinbefore specified, such sum for this purpose not to exceed two hundred and fifty thousand dollars in any one year.

The work of all health centers, including hospitals, clinics, laboratories, et cetera, connected therewith, shall be inspected and standardized by the state department of health, and all the state grants herein provided for shall be paid only on the written approval of the state commissioner of health after inspection of such center and the work done therein.

Provision shall be made by the state commissioner of health for occasional or periodical consultations and clinics at the health centers by specialists in medicine and surgery. To these consultations and clinics health officers and physicians may bring their patients for assistance in diagnosis and for advice as to treatment. Persons able to pay in whole or in part for consultative services shall be charged a reasonable sum therefor and the sum so received shall be paid into the treasury of the health center. It is not intended that this arrangement shall in any way affect the private relation which may exist between the patient and his own physician who brings him to the health center.

Health center laboratories shall be under the supervision of the director of the state health department laboratories and the facilities of the state laboratory service shall be available at all times to supplement those of the laboratories of the health centers.

§ 2. There is hereby appropriated out of any moneys in the treasury of the state not otherwise appropriated, to be available on the first day of July, nineteen hundred and twenty, the sum of one hundred thousand dollars ($100,000) for carrying out the purpose of this act and for the expenses incurred by the state department of health in putting this act in operation, to be payable by the state treasurer on the warrant of the comptroller on the certificate of the state commissioner of health.

§ 3. This act shall take effect immediately.

STATE OF NEW YORK

No. 2621 Int. 2355

IN ASSEMBLY

March 5, 1946

Introduced by Mr. STUART—read twice and ordered printed, and when printed to be committed to the Committee on Finance

AN ACT

To amend the public health law, in relation to state aid for public health work and the organization, establishment and operation of certain health districts

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. The article heading of article two-b of chapter forty-nine of the laws of nineteen hundred nine, entitled "An act in relation to the public health, constituting chapter forty-five of the consolidated laws," such article having been added by chapter six hundred sixty-two of the laws of nineteen hundred twenty-three, is hereby amended to read as follows:

ARTICLE [II-B] *2-B*

STATE AID [TO COUNTIES] *FOR PUBLIC HEALTH WORK*

§ 2. Section nineteen of such chapter, as added by chapter six hundred sixty-two of the laws of nineteen hundred twenty-three and last amended by chapter seven hundred twenty-two of the laws of nineteen hundred thirty, is hereby amended to read as follows:

§ 19. State aid to counties *and certain cities* engaging in public health work. *1. As used in this article:*

(a) "County" means any county of the state other than one wholly embraced within a city.

(b) "City" means each city of the state having a population of fifty thousand or more, according to the last preceding federal census, but does not include any such city which is included as a part of a county health district pursuant to section twenty-b of this chapter.

(c) "Municipality" means a county or city.

(d) "Governing body" means the board of supervisors of a county or the common council, city council or other legislative body of a city.

2. Whenever the board of supervisors of any county shall appropriate and expend moneys for the construction, establishment or maintenance by such county of a county, community, or other public hospital, clinic, dispensary or similar institution, or for the purpose of defraying the expenses of such county in any public enterprise or activity for the improvement of the public health, or any public health work undertaken by such county, within limits to be prescribed by the state commissioner of health, such county shall receive state aid in the manner and subject to the conditions prescribed in this article *unless state aid is otherwise specifically provided for any such purpose by this chapter or any other law.* [The legislature from time to time shall make appropriations for the purpose of rendering such state aid. The state commissioner of health is hereby empowered to prescribe limitations upon the aid to be granted, under applications now pending or hereafter made.]

EXPLANATION—Matter in *italics* is new; matter in brackets [ ] is old law to be omitted.

3. Whenever any city shall appropriate and expend moneys for the purpose of defraying the expenses of such city in any public enterprise or activity for the improvement of the public health, or any public health work undertaken by such city, within limits to be prescribed by the state commissioner of health, such city shall receive state aid in the manner and subject to the conditions prescribed in this chapter unless state aid is otherwise specifically provided for any such purpose by this chapter or any other law.

§ 3. Section nineteen-a of such chapter, as added by chapter six hundred sixty-two of the laws of nineteen hundred twenty-three and amended by chapter two hundred seventy-eight of the laws of nineteen hundred twenty-four, is hereby amended to read as follows:

§ 19-a. Approval of state commissioner of health. It shall be the duty of the state commissioner of health to formulate standards of construction, equipment, service, administration and work which must be complied with by such [counties] *municipalities* in order to be entitled to state aid, and no state aid shall be given to any [county] *municipality* unless the state commissioner of health, after inspection and examination by him or his representative, shall make his certificate that such construction, equipment, service, administration or work is necessary to the public health and conforms to the standards so established therefor, and to the limits prescribed by him as required by section nineteen of this [article] *chapter.*

§ 4. Section nineteen-b of such chapter, as added by chapter six hundred sixty-two of the laws of nineteen hundred twenty-three and last amended by chapter seven hundred thirty-two of the laws of nineteen hundred forty, is hereby repealed, and such chapter is hereby amended by inserting therein in lieu thereof a new section, to be section nineteen-b, to read as follows:

§ 19-b. Amount of state aid; procedure. 1. The board of supervisors of each county or the common council or other body exercising similar powers of each city desiring to make application for state aid under this article shall on such dates as may be fixed by the state commissioner of health submit to him the request of such county or city for such state aid and shall support such request with such information as the state commissioner of health may require. The state commissioner of health shall prescribe the form in which such information shall be submitted.

2. State aid reimbursement shall be granted under the provisions of this article in accordance with the following schedule: Fifty per centum of the amount of money expended or to

be expended by a county not organized as a county department of health; fifty per centum of the amount of money expended or to be expended by a department of health of a city having a population of fifty thousand or more, according to the last preceding federal census; where a city or cities each having a population of fifty thousand or more, according to the last preceding federal census, contained in a county which is organized as a county health district exclusive of such city or cities as specified in section twenty-b of this chapter, takes or take joint action with such county for the establishment of an integrated health service, such city or cities and such county shall each be entitled to receive reimbursement in the amount of seventy-five per centum of the first one hundred thousand dollars expended or to be expended by each for such health service, and in the amount of fifty per centum of all money so expended in excess of one hundred thousand dollars; on account of money expended or to be expended by a county department of health, reimbursement in the amount of seventy-five per centum of the first one hundred thousand dollars and fifty per centum of all money expended in excess of one hundred thousand dollars.

3. Reimbursement of the state's share of expenditures made by counties prior to the first day of January, nineteen hundred forty-seven shall be made in accordance with the provisions of former section nineteen-b of this chapter as it existed immediately prior to such date.

§ 5. Section twenty-b of such chapter, as added by chapter five hundred nine of the laws of nineteen hundred twenty-one, as amended, is hereby amended to read as follows:

§ 20-b. County *and part-county* health districts. 1. Definitions. Whenever used in [the public health law] *this section* the term "county health district" shall mean a [county] health district *comprising the entire county* heretofore or hereafter established pursuant to the provisions of this section; *the term "part-county health district" shall mean all that part of a county outside of a city or cities having a population of fifty thousand or more heretofore or hereafter established as a health district pursuant to the provisions of this section;* the term "county department of health" shall mean that division of the county government having jurisdiction over the public health of [the] *a* county *or part-county* health district; the term "[county] board of health" shall mean the board of health of such county *or part-county* health district; the term "county health commissioner," shall mean the executive officer of such county department of health*; and the term "health district", unless otherwise designated, shall mean either a county health district or a part-county health district.*

2. The board of supervisors of any county, with the approval of the state commissioner of health, shall have power to establish [such] *a* county [or a part thereof as a county] *or part-county* health district and in such event shall appoint a [county] board of health for such county *or part-county* health district. No city or any part thereof shall be included as a part of any such [county] health district unless the mayor and common council of such city or the officials exercising similar powers shall have consented thereto *and, in respect of cities having a population of fifty thousand or more, according to the last preceding federal census, unless the supervisors representing that part of the county outside such city shall have consented thereto.*

In a county containing one or more cities having a population of fifty thousand or more, according to the last preceding federal census, which are not to be included in a county health district, the supervisors representing that part of the county outside of such city or cities may petition the board of supervisors to establish such part of the county as a part-county health district and, upon receiving such petition, the board of supervisors shall forthwith file a certified copy of such petition with the state commissioner of health. If after a reasonable period of time following such petition to the board of supervisors, a part-county or county health district has not been established in such county, which district, in the opinion of the state commissioner of health, meets the standards of administration, service and work necessary to qualify for state aid, he may refuse state aid reimbursement of expenditures made by such city or cities until such a part-county or county health district has been established or until such petition has been withdrawn.

Whenever the provisions of this section shall have been proposed to be adopted in any county, and proceedings have been taken to establish a county *or a part-county* health district within any such county, the board of supervisors shall notify the state commissioner of health in writing of the proposed establishment of such county *or part-county* health district, and in such notice shall state the extent of the territory intended to be included within such district. The consent of the state commissioner of health to the establishment of any such [county] health district shall be evidenced by a certificate, setting forth the approval of the state commissioner of health to the establishment of such [county] health district and such certificate shall be filed with the clerk of the board of supervisors.

3. The county *or part-county* board of health shall consist of seven members, except that each city which becomes a part of the [county] health district shall be entitled to one additional representative on the [county] board of health to be appointed by the board of supervisors from a list of three persons submitted by the mayor or other administrative head of such city and which city representative so appointed shall have all the powers and duties conferred upon other members of said board and whose term of office shall be six years. The members of the [county] board of health shall be residents of the [county] health district, one of whom shall be a member of the board of supervisors selected by the board of supervisors, and at least three of whom shall be physicians licensed to practice in the state of New York. The county medical society of the county in which a [county] health district is established may submit to the board of supervisors a list of physicians from which the board of supervisors may choose the medical members of the [county] board of health. The term of office of each appointive member of said [county] board of health shall be six years, and the term of one of the members shall expire annually. The first appointments shall be made for the respective terms of six, five, four, three, two and one years. Vacancies shall be filled by appointment for the unexpired terms.

4. The members of the [county] board of health shall receive for attendance at meetings of the board a per diem compensation which shall be fixed by the board of supervisors and in addition thereto they shall be allowed actual and necessary traveling expenses, to be audited and paid in the same manner as other expenses of such board of health.

5. In counties having a county auditor or county comptroller, all charges and other expenses of such district shall be audited and paid in the same manner as other charges against the county. In counties not having a county auditor or county comptroller, all accounts, charges, claims and demands of such [county] health district shall be presented to and audited by the [county] board of health and paid by the county treasurer upon warrants of the [county] board of health within the limits of the appropriation made therefor.

6. Upon the establishment of a [county] board of health as herein provided it shall exercise all the powers and perform all duties of local boards of health, and such [county] board of health may formulate, promulgate, adopt and publish rules, regulations, orders and directions for the security of life and health in the [county] health district which shall not be inconsistent with the state sanitary code. Every rule, regulation, order and direction adopted by a [county] board of health shall state the date on which it takes effect and a copy thereof signed by the county commissioner of health or his deputy shall be filed as a public record in the state department of health, the county *or part-county* department of health and in the office of the county clerk and shall be published in such manner as the [county] board of health may from time to time determine. Such rules, regulations, orders and directions shall be known as the sanitary code of such [county] health district. The county commissioner of health or his

deputy shall furnish certified copies of such code and its amendments for a fee of one dollar and such certified copies shall be received in evidence in all courts or other judicial proceedings in the state. The provisions of such sanitary code shall have the force and effect of law. Any violation of or nonconformance with any provision of such sanitary code or of any rule, regulation, order or special direction duly made thereunder shall constitute a misdemeanor punishable by a fine of not more than fifty dollars or by imprisonment for not more than six months or by both such fine and imprisonment.

7. Such [county] board of health shall elect annually one of its number as president and another as vice-president. It shall also appoint a county health commissioner, who, in addition to his duties as health commissioner may be designated by the [county] board of health to act as secretary without extra compensation. Such county health commissioner shall possess such qualifications for office as shall have been approved by the public health council. He shall serve for a term of six years and shall not be removed during the term for which he shall have been appointed, except upon written charges after a hearing and upon notice. He shall devote his whole time to the duties of his office and shall receive such compensation as the [county] board of health shall determine within the limits of the appropriations made by the board of supervisors. He shall, within his district, possess all the powers conferred upon and perform all the duties required of local health officers. Local health officers who continue to hold office as herein provided after the establishment of a [county] health district shall be deputies of the county health commissioner, who may require any such local health officer to perform within his local jurisdiction any such duty. The county health commissioner may, upon the authorization of the [county] board of health and within the limits of the appropriations therefor, appoint such additional deputies, assistant deputies and other employees as may be required to fulfill in the [county] health district the purposes of this section. Such deputies and assistant deputies shall have the qualifications prescribed for health officers by regulation of the public health council.

The county health commissioner may designate in writing a deputy to whom shall be delegated all the powers and duties of the county health commissioner when such county health commissioner is unable to act by reason of absence or disability.

The [county] board of health shall have the power to remove the health officer of any local health district included within such county *or part-county* health district or any deputy or assistant deputy of the county health commissioner for cause, upon charges, and after such health officer or deputy or assistant deputy has, with due notice, been given an opportunity to be heard. The proceedings in connection with such removal shall be subject to review by the state commissioner of health, who within thirty days of the receipt of an order of a [county] board of health removing such local health officer, may revoke such order whereupon such order shall be void.

8. [Except as hereinafter provided, local] *Local* health districts within the area of any county *or part-county* health district shall continue to exist as subdivisions of [the county] *such* health district, and the local boards of health shall continue to exist and to retain their powers and duties subject to the rulings and regulations of the [county] board of health, and may continue to appoint local health officers for such local health districts as provided by law. [In county health districts when the county board of health shall have been appointed and organized and the county health commissioner shall have been appointed and has qualified, the local boards of health and health officers of all incorporated villages having a population of less than three thousand according to the latest federal census and of all consolidated health districts not containing a city or village having a population of three thousand or more according to the latest federal census and of all towns included in such district, shall thereupon cease to exist as such.]

The governing authorities of any city, *village or town* [or any village containing a population of three thousand or more according to the latest federal census,] or *the board of health of* any consolidated health district [containing such a village] may abolish such city, village, *town* or consolidated health district as a local health district, whereupon all the powers and duties of the local board of health of such local health district shall devolve upon the [county] health board and all the powers and duties of the local health officer of such local health district shall devolve upon the county health commissioner. [A] *The governing authorities of a* town [board of any town] *or village*, the local board of health of which has been abolished pursuant to the provisions of this section, when authorized by a proposition submitted and adopted in the manner provided by law, may employ a public health nurse or public health nurses, qualified as provided by regulation of the public health council, and make the necessary appropriation therefor. Such public health nurse, or nurses, shall work under the direction of the county health commissioner.

The governing authorities of any city which has consented to be included in a [county] health district, may, at any time after three years shall have elapsed since such city has been included in a [county] health district, by resolution adopted by said authorities, provide for the withdrawal of such city from a [county] health district. Before such action is taken an opportunity shall be given for a public hearing before such governing authorities. Public notice shall be given and the [county] health board shall be notified in writing, at least thirty days in advance, of the time and place of such hearing. Such action by the said governing authorities shall become effective at a time to be stated in the resolution, which said time shall be not less than thirty days from the date of the adoption of said resolution. Upon the date when such resolution shall become effective, the local health district of such city shall be reinstated and it shall have all the powers of a local health district as though such city had not been included in the [county] health district pursuant to the provisions of this act.

If a county *or part-county* health district as heretofore or hereafter established by a board of supervisors shall by its terms contain a portion of any village which lies partly within said county and partly within some other county, said village, without regard to population, shall continue its *local* health district organization in the same manner as before, in which case its health officer acting within the county *or part-county* health district shall be a deputy of the county health commissioner with reference to acts performed within said county *or part-county* health district. Provided, however, said village may, by resolution of its village board, limit its *local* health district to that portion of the village lying in the county outside of the county *or part-county* health district, in which event the compensation of the local health officer shall be based upon the number of inhabitants in the reduced village health district, and the residents of that portion of the village lying within the county *or part-county* health district shall not be taxed by the village for the support of such reduced *local* health district.

9. The health officer of each city, village, and consolidated health district included as part of any county *or part-county* health district, shall transmit daily all original reports of communicable disease cases, and all registrar's reports of deaths from communicable disease, to the county health commissioner. The county health commissioner shall transmit the original reports of communicable disease cases, within twenty-four hours after he receives them, to the state health department.

10. Annually the [county] board of health shall prepare an estimate of the necessary expenses of such county *or part-county* health district, for the ensuing fiscal year which shall be transmitted to the board of supervisors of the county within such period of time as shall enable the board of supervisors to inquire into the necessity for the items of such estimate. The board of supervisors shall levy a tax upon the taxable property within the county *or part-county* health district, sufficient to provide such sums as the board of supervisors may deem necessary to meet the expenses of such [county] health district. In preparing the items of any estimate of the expense of a county *or part-county* board of health, the board of supervisors may lawfully include therein and approve all items of expenses which may in any degree

tend to promote the efficiency of the administration of the provisions of the public health law and other regulations adopted pursuant to the authority thereof.

11. The board of supervisors of any county in which a county health district has been established, the boundaries of which are coterminous with the county, shall have power to abolish the board of managers of the county laboratory of such county, established and operated under the provisions of sections twenty-c to twenty-f, both inclusive, of [the public health law] *this chapter*, and to confer the powers and duties of such board of managers of such county laboratory upon the county board of health. The board of supervisors of any such county, with the approval of the state commissioner of health, may abolish the board of managers of the county tuberculosis hospital established and operated in such county under the provisions of sections forty-five to forty-nine-e, both inclusive, of the county law, and confer the powers and duties of such board of managers upon the county board of health.

12. The board of supervisors of any county in which a county *or part-county* health district has been or may be established, *with the consent of the supervisors representing that part of a county included in the district in respect to a part-county health district,* may abolish such district at any time after three years shall have elapsed following its establishment, provided, however, that before such action may be taken an opportunity shall be given for a public hearing. Public notice shall be given and the state commissioner of health shall be notified in writing, at least thirty days in advance, of the time and place of such hearing. Such action by the board of supervisors shall become effective thirty days after the adoption of the resolution to abolish such [county] health district, and at the end of such period the terms of office of the members of the [county] board of health and of the county health commissioner shall terminate.

§ 6. This act shall take effect immediately, except section four, which shall take effect January first, nineteen hundred forty-seven, and except that state aid reimbursement authorized by the amendments to the public health law made by this act shall be effective and accrue to the benefit of counties and cities on and after January first, nineteen hundred forty-seven.

APPENDIX B

TABLE I. *Land Area and Total Population Per Square Mile in Each Health Service Region and District Shown in Figure 5, New York State, Exclusive of New York City, 1940*

REGION AND DISTRICT	Population (1940 census)	Land Area (Square Miles) (1940 census)	Population Per Square Mile
New York State (exclusive of New York City)	6,024,147	47,630	126.5
Albany region	991,394	13,881	71.4
Districts:			
Albany-Hudson-Troy	433,351	3,117	139.0
Amsterdam-Gloversville	111,927	2,653	42.2
Cooperstown-Oneonta	87,071	2,483	35.1
Glens Falls	82,761	1,720	48.1
Plattsburgh	88,184	2,885	30.6
Schenectady	188,100	1,023	183.9
Buffalo region	1,230,594	5,101	241.2
Districts:			
Batavia-Warsaw	75,875	1,099	69.0
Buffalo-Niagara Falls	958,487	1,587	604.0
Jamestown	123,580	1,080	114.4
Olean	72,652	1,335	54.4
New York region (exclusive of New York City)	1,654,050	5,844	283.0
Districts:			
Bay Shore	197,355	922	214.1
Hempstead	406,748	300	1,355.8
Kingston	87,017	1,143	76.1
Middletown-Newburgh	178,014	1,815	98.1
Poughkeepsie	120,542	816	147.7
White Plains	664,374	848	783.5
Rochester region	865,972	6,836	126.7
Districts:			
Clifton Springs	97,420	1,323	73.6
Elmira	86,697	743	116.7
Hornell	124,608	2,456	50.7
Rochester	557,247	2,314	240.8
Syracuse region	1,282,137	15,968	80.3
Districts:			
Auburn	65,508	699	93.7
Binghamton	229,275	2,143	107.0
Ithaca	42,340	491	86.2
Malone-Saranac Lake	44,286	1,685	26.3
Ogdensburg	91,098	2,772	32.9
Syracuse	439,649	2,923	150.4
Utica	263,163	2,669	98.6
Watertown	106,818	2,586	41.3

TABLE II. *Male and Female Population and Per Cent Male and Female in Each Health Service Region and District Shown in Figure 5, New York State, Exclusive of New York City, 1940*

REGION AND DISTRICT	Population (1940 Census)			Per Cent		
	Total	Male	Female	Total	Male	Female
New York State (exclusive of New York City)	6,024,147	3,014,033	3,010,114	100.0	50.0	50.0
Albany region	991,394	497,512	493,882	100.0	50.2	49.8
Districts:						
Albany-Hudson-Troy	433,351	213,999	219,352	100.0	49.4	50.6
Amsterdam-Gloversville	111,927	55,666	56,261	100.0	49.7	50.3
Cooperstown-Oneonta	87,071	44,327	42,744	100.0	50.9	49.1
Glens Falls	82,761	42,000	40,761	100.0	50.7	49.3
Plattsburgh	88,184	47,466	40,718	100.0	53.8	46.2
Schenectady	188,100	94,054	94,046	100.0	50.0	50.0
Buffalo region	1,230,594	616,948	613,646	100.0	50.1	49.9
Districts:						
Batavia-Warsaw	75,875	39,617	36,258	100.0	52.2	47.8
Buffalo-Niagara Falls	958,487	478,921	479,566	100.0	50.0	50.0
Jamestown	123,580	61,532	62,048	100.0	49.8	50.2
Olean	72,652	36,878	35,774	100.0	50.8	49.2
New York region (exclusive of New York City)	1,654,050	823,929	830,121	100.0	49.8	50.2
Districts:						
Bay Shore	197,355	100,377	96,978	100.0	50.9	49.1
Hempstead	406,748	200,334	206,414	100.0	49.3	50.7
Kingston	87,017	44,468	42,549	100.0	51.1	48.9
Middletown-Newburgh	178,014	92,215	85,799	100.0	51.8	48.2
Poughkeepsie	120,542	60,427	60,115	100.0	50.1	49.9
White Plains	664,374	326,108	338,266	100.0	49.1	50.9
Rochester region	865,972	431,419	434,553	100.0	49.8	50.2
Districts:						
Clifton Springs	97,420	49,333	48,087	100.0	50.6	49.4
Elmira	86,697	43,684	43,013	100.0	50.4	49.6
Hornell	124,608	63,708	60,900	100.0	51.1	48.9
Rochester	557,247	274,694	282,553	100.0	49.3	50.7
Syracuse region	1,282,137	644,225	637,912	100.0	50.2	49.8
Districts:						
Auburn	65,508	33,672	31,836	100.0	51.4	48.6
Binghamton	229,275	113,974	115,301	100.0	49.7	50.3
Ithaca	42,340	20,978	21,362	100.0	49.5	50.5
Malone-Saranac Lake	44,286	22,737	21,549	100.0	51.3	48.7
Ogdensburg	91,098	46,280	44,818	100.0	50.8	49.2
Syracuse	439,649	219,977	219,672	100.0	50.0	50.0
Utica	263,163	131,983	131,180	100.0	50.2	49.8
Watertown	106,818	54,624	52,194	100.0	51.1	48.9

TABLE III. *Age Distribution of the Population in Each Health Service Region and District Shown in Figure 5, New York State, Exclusive of New York City, 1940*

REGION AND DISTRICT	Population (1940 Census)						Per Cent of Total Population in Each Age Group					
	Total	Age (years)					Total	Age (years)				
		Under 15	15–29	30–44	45–59	60 and Over		Under 15	15–29	30–44	45–59	60 and Over
New York State (exclusive of New York City)	6,024,147	1,311,738	1,491,188	1,347,049	1,111,160	763,012	100.0	21.8	24.8	22.4	18.4	12.7
Albany region	991,394	209,084	240,458	213,987	186,266	141,599	100.0	21.1	24.3	21.6	18.8	14.3
Districts:												
Albany-Hudson-Troy	433,351	87,926	102,886	96,834	83,717	61,988	100.0	20.3	23.7	22.3	19.3	14.3
Amsterdam-Gloversville	111,927	22,249	28,013	22,945	21,812	16,908	100.0	19.9	25.0	20.5	19.5	15.1
Cooperstown-Oneonta	87,071	19,721	19,959	17,190	15,539	14,662	100.0	22.6	22.9	19.7	17.8	16.8
Glens Falls	82,761	18,876	19,558	17,037	14,831	12,459	100.0	22.8	23.6	20.6	17.9	15.1
Plattsburgh	88,184	23,007	22,852	18,200	13,720	10,405	100.0	26.1	25.9	20.6	15.6	11.8
Schenectady	188,100	37,305	47,190	41,781	36,647	25,177	100.0	19.8	25.1	22.2	19.5	13.4
Buffalo region	1,230,594	277,519	318,331	273,674	223,666	137,404	100.0	22.6	25.9	22.2	18.2	11.2
Districts:												
Batavia-Warsaw	75,875	17,203	18,999	15,059	13,564	11,050	100.0	22.7	25.0	19.8	17.9	14.6
Buffalo-Niagara Falls	958,487	215,645	251,529	218,366	174,429	98,518	100.0	22.5	26.2	22.8	18.2	10.3
Jamestown	123,580	26,944	29,944	25,711	22,868	18,113	100.0	21.8	24.2	20.8	18.5	14.7
Olean	72,652	17,727	17,859	14,538	12,805	9,723	100.0	24.4	24.6	20.0	17.6	13.4
New York region (exclusive of New York City)	1,654,050	352,247	398,451	409,858	306,334	187,160	100.0	21.3	24.1	24.8	18.5	11.3
Districts:												
Bay Shore	197,355	38,901	44,329	47,320	40,719	26,086	100.0	19.7	22.5	24.0	20.6	13.2
Hempstead	406,748	93,969	95,214	108,405	72,900	36,260	100.0	23.1	23.4	26.7	17.9	8.9
Kingston	87,017	18,262	20,277	18,612	16,462	13,404	100.0	21.0	23.3	21.4	18.9	15.4
Middletown-Newburgh	178,014	35,858	43,886	38,282	33,992	25,996	100.0	20.1	24.7	21.5	19.1	14.6
Poughkeepsie	120,542	23,545	28,404	27,463	23,491	17,639	100.0	19.5	23.6	22.8	19.5	14.6
White Plains	664,374	141,712	166,341	169,776	118,770	67,775	100.0	21.3	25.0	25.6	17.9	10.2
Rochester region	865,972	183,260	214,221	183,242	164,495	120,754	100.0	21.2	24.7	21.2	19.0	13.9
Districts:												
Clifton Springs	97,420	21,134	21,819	18,729	18,907	16,831	100.0	21.7	22.4	19.2	19.4	17.3
Elmira	86,697	18,988	22,094	17,657	15,807	12,151	100.0	21.9	25.5	20.4	18.2	14.0
Hornell	124,608	30,927	28,684	24,410	22,384	18,203	100.0	24.8	23.0	19.6	18.0	14.6
Rochester	557,247	112,211	141,624	122,446	107,397	73,569	100.0	20.1	25.4	22.0	19.3	13.2
Syracuse region	1,282,137	289,628	319,727	266,288	230,399	176,095	100.0	22.6	24.9	20.8	18.0	13.7
Districts:												
Auburn	65,508	13,807	16,017	13,135	12,143	10,406	100.0	21.1	24.5	20.1	18.5	15.9
Binghamton	229,275	53,163	57,378	49,746	39,810	29,178	100.0	23.2	25.0	21.7	17.4	12.7
Ithaca	42,340	9,147	10,652	8,935	7,306	6,300	100.0	21.6	25.2	21.1	17.3	14.9
Malone-Saranac Lake	44,286	11,883	10,631	8,741	7,327	5,704	100.0	26.8	24.0	19.7	16.5	12.9
Ogdensburg	91,098	24,004	21,646	17,588	14,634	13,226	100.0	26.3	23.8	19.3	16.1	14.5
Syracuse	439,649	96,736	109,679	93,536	80,414	59,284	100.0	22.0	24.9	21.3	18.3	13.5
Utica	263,163	55,217	68,134	53,821	50,229	35,762	100.0	21.0	25.9	20.5	19.1	13.6
Watertown	106,818	25,671	25,590	20,786	18,536	16,235	100.0	24.0	24.0	19.5	17.4	15.2

TABLE IV. *Urban and Rural Population and Per Cent Urban and Rural in Each Health Service Region and District Shown in Figure 5, New York State, Exclusive of New York City, 1940*

REGION AND DISTRICT	Population (1940 Census)			Per Cent		
	Total	Urban [1]	Rural [1]	Total	Urban	Rural
New York State (exclusive of New York City)	6,024,147	3,710,898	2,313,249	100.0	61.6	38.4
Albany region	991,394	568,279	423,115	100.0	57.3	42.7
Districts:						
Albany-Hudson-Troy	433,351	277,548	155,803	100.0	64.0	36.0
Amsterdam-Gloversville	111,927	72,829	39,098	100.0	65.1	34.9
Cooperstown-Oneonta	87,071	21,039	66,032	100.0	24.2	75.8
Glens Falls	82,761	37,134	45,627	100.0	44.9	55.1
Plattsburgh	88,184	29,585	58,599	100.0	33.5	66.5
Schenectady	188,100	130,144	57,956	100.0	69.2	30.8
Buffalo region	1,230,594	927,767	302,827	100.0	75.4	24.6
Districts:						
Batavia-Warsaw	75,875	29,702	46,173	100.0	39.1	60.9
Buffalo-Niagara Falls	958,487	789,530	168,957	100.0	82.4	17.6
Jamestown	123,580	75,812	47,768	100.0	61.3	38.7
Olean	72,652	32,723	39,929	100.0	45.0	55.0
New York region (exclusive of New York City)	1,654,050	909,446	744,604	100.0	55.0	45.0
Districts:						
Bay Shore	197,355	34,424	162,931	100.0	17.4	82.6
Hempstead	406,748	195,750	210,998	100.0	48.1	51.9
Kingston	87,017	36,505	50,512	100.0	42.0	58.0
Middletown-Newburgh	178,014	84,645	93,369	100.0	47.5	52.5
Poughkeepsie	120,542	56,477	64,065	100.0	46.9	53.1
White Plains	664,374	501,645	162,729	100.0	75.5	24.5
Rochester region	865,972	538,644	327,328	100.0	62.2	37.8
Districts:						
Clifton Springs	97,420	39,646	57,774	100.0	40.7	59.3
Elmira	86,697	55,418	31,279	100.0	63.9	36.1
Hornell	124,608	45,049	79,559	100.0	36.2	63.8
Rochester	557,247	398,531	158,716	100.0	71.5	28.5
Syracuse region	1,282,137	766,762	515,375	100.0	59.8	40.2
Districts:						
Auburn	65,508	35,753	29,755	100.0	54.6	45.4
Binghamton	229,275	133,262	96,013	100.0	58.1	41.9
Ithaca	42,340	19,730	22,610	100.0	46.6	53.4
Malone-Saranac Lake	44,286	19,466	24,820	100.0	44.0	56.0
Ogdensburg	91,098	39,991	51,107	100.0	43.9	56.1
Syracuse	439,649	293,702	145,947	100.0	66.8	33.2
Utica	263,163	183,688	79,475	100.0	69.8	30.2
Watertown	106,818	41,170	65,648	100.0	38.5	61.5

[1] U. S. Census definition: persons living in incorporated places of 2,500 or more; the remainder of the population is classified as rural.

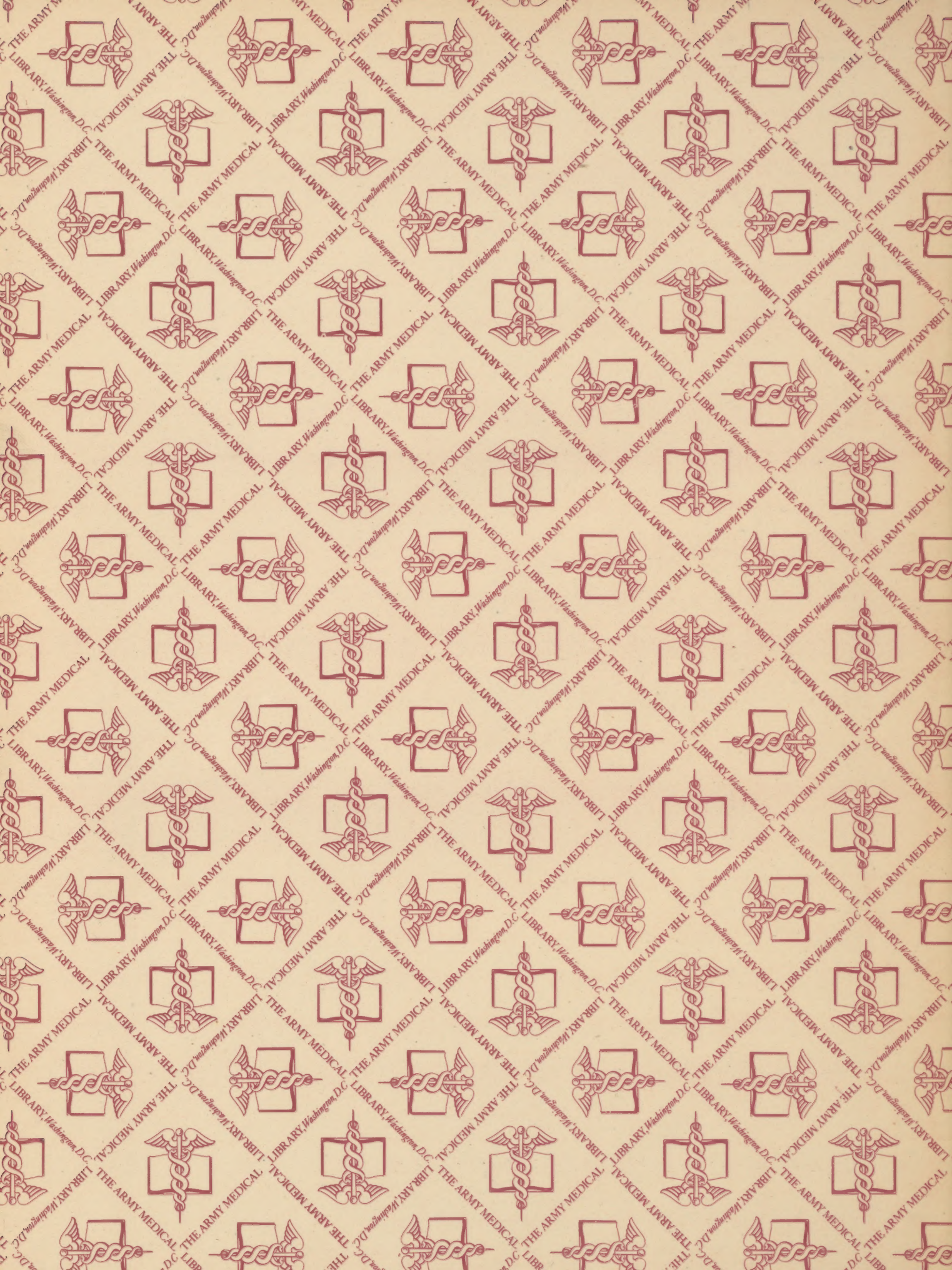
TABLE V. *Area, Population, Hospitals, and Physicians in Each County, New York State, Exclusive of New York City, 1944*

COUNTY	Population (1940 Census)		Land Area (Sq. Miles)	Number of Hospitals [2]			Bed Capacity			Number of Physicians [3]
	Total (Inc. Federal and State Institutions)	In Federal and State Institutions [1]		All Hospitals	Registered by American Medical Association	Approved by American College of Surgeons	All Hospitals	Registered by American Medical Association	Approved by American College of Surgeons	
New York State (exclusive of New York City)	6,024,147	102,685	47,630	281	202	135	23,182	22,157	19,485	8,032
Albany	221,315	.....	531	6	6	5	958	958	893	344
Allegany	39,681	.....	1,048	4	3	2	106	94	80	38
Broome	165,749	2,750	710	6	5	4	1,023	1,011	992	207
Cattaraugus	72,652	.....	1,335	7	5	2	291	286	185	66
Cayuga	65,508	1,666	699	3	2	2	302	299	299	72
Chautauqua	123,580	.....	1,080	6	4	2	403	360	226	113
Chemung	73,718	1,670	412	2	2	2	436	436	436	82
Chenango	36,454	216	908	8	2	1	141	90	76	31
Clinton	54,006	3,199	1,059	2	2	2	191	191	191	45
Columbia	41,464	386	643	2	2	1	135	135	100	37
Cortland	33,668	.....	502	2	2	1	143	143	128	34
Delaware	40,989	.....	1,470	11	4	..	139	94	.....	41
Dutchess	120,542	15,178	816	4	4	3	396	396	346	165
Erie	798,377	4,736	1,054	22	16	10	3,363	3,203	2,786	1,163
Essex	34,178	330	1,826	7	5	2	124	115	71	31
Franklin	44,286	419	1,685	3	3	2	162	162	132	52
Fulton	48,597	.....	497	1	1	1	133	133	133	61
Genesee	44,481	275	501	3	2	2	140	138	138	42
Greene	27,926	.....	653	1	1	1	70	70	70	32
Hamilton	4,188	.....	1,747	..	..	..	.....	.....	.....	7
Herkimer	59,527	.....	1,442	3	3	1	190	190	76	58
Jefferson	84,003	.....	1,293	11	2	2	392	299	299	88
Lewis	22,815	.....	1,293	1	1	1	44	44	44	20
Livingston	38,510	2,547	638	2	1	1	54	42	42	35
Madison	39,598	.....	661	6	3	1	129	117	80	42
Monroe	438,230	3,171	673	10	8	7	1,884	1,826	1,809	737
Montgomery	59,142	.....	409	2	2	2	239	239	239	58
Nassau	406,748	.....	300	11	6	6	882	809	809	656
Niagara	160,110	.....	533	5	5	2	588	588	353	162
Oneida	203,636	7,807	1,227	9	7	6	860	856	656	254
Onondaga	295,108	1,039	792	11	9	6	1,226	1,222	1,091	399
Ontario	55,307	1,182	649	3	3	3	497	497	497	66
Orange	140,113	3,278	829	9	7	7	579	384	328	143
Orleans	27,760	.....	396	2	2	1	62	62	38	23
Oswego	71,275	.....	968	3	2	1	156	150	61	61
Otsego	46,082	219	1,013	4	3	1	199	197	95	51
Putnam	16,555	.....	235	2	1	..	52	45	.....	14
Rensselaer	121,834	.....	665	5	4	3	611	602	578	145
Rockland	74,261	10,081	178	3	2	2	200	183	183	86
St. Lawrence	91,098	2,103	2,772	8	3	4	335	252	301	77
Saratoga	65,606	.....	814	3	3	1	131	131	90	59
Schenectady	122,494	.....	209	3	3	1	488	488	400	184
Schoharie	20,812	.....	625	3	1	..	15	8	.....	22
Schuyler	12,979	.....	331	1	1	..	36	36	.....	10
Seneca	25,732	2,969	330	2	2	..	55	55	.....	26
Steuben	84,927	1,644	1,480	5	5	4	328	328	311	76
Suffolk	197,355	24,182	922	10	7	4	503	461	335	263
Sullivan	37,901	621	986	5	4	..	112	99	.....	47
Tioga	27,072	.....	525	1	1	1	67	67	67	24
Tompkins	42,340	201	491	3	1	1	172	147	147	62
Ulster	87,017	1,429	1,143	5	3	2	220	212	154	77
Warren	36,035	.....	883	1	1	1	120	120	120	53
Washington	46,726	1,457	837	5	2	1	128	116	100	46
Wayne	52,747	2,515	607	4	4	..	99	99	.....	54
Westchester	573,558	3,166	435	17	17	15	2,700	2,700	2,488	1,159
Wyoming	31,394	2,249	593	2	1	1	123	122	122	31
Yates	16,381	.....	344	1	1	1	50	50	50	21

[1] Estimated by the New York State Department of Health as of April 1, 1940.

[2] There are included only the general and special hospitals reported to provide the following types of services: general, ENT, industrial, maternity, isolation, communicable disease, and pediatric. State and Federal hospitals are excluded. Also excluded are hospitals for tuberculosis, nervous and mental, orthopedic, chronic and incurable; infirmaries of institutions; convalescent hospitals and homes, country branches of New York City hospitals; and hospitals operated by private organizations for the benefit of their members.

[3] Includes physicians in military service, but excludes physicians in full-time positions in Federal and State institutions, public health, and physicians retired or not engaged in practice at time of November 1, 1944, survey of the New York State Department of Health.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